

Date: _____

Healing the Quantum Way Holistic Practice

8300 Morro Rd, Atascadero, CA
in El Morro Plaza
(805) 610-2642

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Place of Birth: _____

Time of Birth: _____

Hm phone #: () _____ Cell phone #: () _____

Female _____ Male _____ e-mail: _____

Who referred you? _____ Do You Have a Pacemaker? _____

| | | | |
|--|--|--|--|
| Number of organs removed | | Rate your personal stress from 1 - 10 | |
| Number of synthetic drugs used currently | | Number of times you use sugar type products per day (including wheat) | |
| Number of cigarettes you smoke a day | | Number of times you exercise per week 20 minutes or more –not work related. | |
| Number of steroid drugs used per year | | Number of alcoholic drinks per day(ave.) | |
| Number of amalgam (silver) fillings | | Number of caffeine products used daily | |
| Number of street drugs used per month | | Number of past toxic exposures (chem., pest, radiation, chemo, etc.) per yr. | |
| Number of known allergies | | Number of past major injuries | |
| Number of unresolved emotional factors | | Number of past major infections | |
| I believe I am responsible for my body 1 – 10 (10 I am completely responsible) | | Number of glasses of water per day | |
| Amount of fat in diet from 10 – 100% | | How many pounds overweight | |

Please check if you have or have had any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Allergies –list major ones | <input type="checkbox"/> Fracture(s) | <input type="checkbox"/> Root Canals – number of |
| _____ | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Scarlet fever |
| _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| _____ | <input type="checkbox"/> Gout | <input type="checkbox"/> Thyroid problems |
| _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Tumor growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High cholesterol | Past surgeries/scars _____ |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Kidney disease | _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Liver disease | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Measles | _____ |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Migraine headaches | _____ |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Mononucleosis | _____ |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Multiple sclerosis | _____ |
| <input type="checkbox"/> Crowns –number of | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Parkinson’s disease | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pneumonia | _____ |
| | <input type="checkbox"/> Polio | |
| | <input type="checkbox"/> Prostate problems | |

Family History: Please indicate if any family members have had or have any of the following medical problems and if so who:

- | | |
|--|--|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Hepatitis/Liver disease _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Alcohol problems _____ | <input type="checkbox"/> Congenital problems _____ |
| <input type="checkbox"/> Mental/Emotional problems _____ | <input type="checkbox"/> Other _____ |

Describe any concerns and your objectives in seeking services here:

Waiver of All Claims:

Nutritional Protocols obtained at Healing the Quantum Way serve as recommendations for clients to naturally support the bodies physiological and biochemical processes, and not to diagnose, treat, cure or prevent any disease or condition. There is no warranty or guarantee expressed or implied in the biofeedback, Acupoint Nutritional Testing and/or supplement protocols and products purchased. You are responsible for the outcome of your current habits and your commitment to health programs. We are here to support you in that endeavor, not to replace your individual and personal responsibility for your health. Some products recommended for clients have not been evaluated by the Food and Drug Administration. Always consult with your professional health care provider or Doctor before changing any medication or adding Vitamins or nutritional supplements to your regime.

Client recognizes there are risks of injury or bodily harm from any ingestion of products into the body from many different causes and the client expressly assumes all such risks and agree to hold Healing the Quantum Way and its practitioners harmless there from. The Client acknowledges and accepts the risks inherent in the use of nutritional products and/or biofeedback. In consideration of Healing the Quantum Way extending products & services, the Client agrees to waive all claims for any injury from any cause against Healing the Quantum Way, its agents or employees, and that Healing the Quantum Way shall not be liable for any injuries or be subject to any claim, demand or damages whatsoever, including without any limitation, those resulting from negligence on the part of Healing the Quantum Way or any of its practitioners or employees.

I understand that the attending practitioner(s) are not allopathic doctors (MDs) and do not portray themselves to be and are providing me with biofeedback and/or Acupoint Nutritional Testing services. Procedures used include stress reduction protocols, nutritional wellness consultation and biofeedback. I fully understand that the attending practitioner(s) do not offer allopathic drug, surgery, chemical stimulants, or any other conventional treatments. In addition, I will not receive a diagnosis, treatment, or prescription for my disease, condition(s), or illness, or have any act performed to me that would constitute the practice of medicine for which a license is required.

I have solicited the attending practitioners' services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health. I am fully aware and release the practitioner(s) to do Acupoint Nutritional Testing, biofeedback testing, wellness consultation and/or other stress reduction protocols. By signing below I acknowledge that I have read and understand all parts of this waiver, that I had the opportunity to ask questions with regard to the described procedures, and that I hereby affirm: I am not here for medical diagnostic or treatment procedures and that I am here on this and subsequent visits solely on my own behalf.

I have hereby read the above and confirm my understanding that services and product obtained at Healing the Quantum Way serve purely to provide nutritional support and/or stress reduction through biofeedback to my body, and are not a source for curing or treating disease. I also understand that it is my responsibility to obtain health care services as needed from appropriate practitioners including, but not limited to Medical Doctors, Chiropractors, Dentists, etc.

Signature of client

Date

Signature of Parent or Guardian if minor

Date

PRICE LIST

(Effective August 2, 2021)

LESLIE

| | | |
|------------------------|-------|----------------------|
| BIOFEEDBACK | \$195 | CASH \$185 |
| NUTRITIONAL ASSESSMENT | \$195 | \$185 |

LAURA

| | |
|-------------------------|-------|
| BIOFEEDBACK (SPECIAL) | \$100 |
| SEKHEM | \$100 |
| EGYPTIAN ENERGY HEALING | \$100 |
| REIKI | \$100 |

DETOX THERAPIES

| | |
|-----------------|-----------------------------|
| BIOMAT® | \$20 <u>OR</u> 10 FOR \$180 |
| FOOT DETOX BATH | \$30 <u>OR</u> 10 FOR \$280 |

CANCELLATION POLICY

Cancellation Policy is 24 hours

If appointments are cancelled, missed, or changed with less notice you will be charged for your appointment unless I am able to fill your appointment time with another client.

SUPPLEMENTS ARE NOT RETURNABLE or REFUNDABLE

Supplements are food and must be in a stable environment.

It is for your safety as my clients.

Thanks for understanding.

Thank you

Signature of client

Date

Signature of Parent or Guardian if minor

Date