Bionetic Biofeedback Stress Response Testing/

Wellness Evaluation Authorization and Release Form

Electro-acupuncture and stress testing provide an opportunity to measure electrical responses and meridian flow of the body. Bio energetic evaluation of the energy flow helps identify various stressors that might impede the electrical process. The evaluation may include recommendations for natural remedies, stress reduction methods and/or nutritional changes designed to balance the energy meridians and enhance overall wellness. These recommendations are not cures for any known diseases, nor have they been clinically proven to eliminate any specific disease process. The bio energetic evaluation is not a method of diagnosing, nor are the suggested remedies designed to replace any of the medications or treatments currently being provided by a primary care practitioner.

1. I fully understand that the attending consultant is not an allopathic doctor (M.D.) and does not pretend to be, but is a Board Certified Naturopathic Doctor, (board certification does not imply being registered or licensed by the state, nor does one need to be. You are being consulted by a traditional/board certified naturopath not practicing medicine) and a Bio Energetic Practitioner, providing services that are not allopathic, but that are within the parameters of a natural health and wellness philosophy.

2. I fully understand that the attending consultant does not offer allopathic drugs, surgery, chemical stimulants or radiation therapy, but is providing information and natural products to restore natural balance and optimum conditions for health and wellness based on the scope of his/her practice.

3. I full understand that the consultant is not diagnosing or treating any illness or disease, but is only measuring the bio energetic balance and overall stress response of the body and that these services may not be generally accepted and/or recommended by allopathic physicians or other health professionals.

4. I fully understand that the attending consultant is in no way encouraging me to terminate or modify and previous or ongoing therapies under the direction of any licensed practitioner, and that the attending consultant can/will not dissuade me from seeking allopathic attention, recommendations or modes of therapy from a licensed practitioner.

5. I presently seek consultations, advice, opinions, and/or programs, tests, evaluations, and/or products within the scope of the attending consultant's wellness practice based upon the principles of bio energetic health and have solicited the attending consultant's 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.

6. If I am accompanied by a minor or an incompetent, I give full faith that I am legally and totally responsible for them.

7. I authorize the attending consultant to provide his/her services to me on my behalf, and hereby release him/her from any and all claims and potential claims arising out if my actions or failure to act upon his/her advice.

8. I give full faith that I have read and understand this document entirely, that I have received a verbal explanation of the same from the attending consultant, and that he/she has answered satisfactorily all of my questions regarding this form.

9. I am willing to declare and repeat under oath all of the above statements by request of the attending consultant.

Client Signature_____ Date_____

Parent or Guardian signature if under 18_____

Individual Health Information Sheet

Name_____ Day Phone_____

Address_____ Night Phone_____

City_____ Cell Phone_____

State/Zip_____ Email_____

Relief from what top 3 symptoms (see back page)_____

Life Goals_____

How much sweaty activity weekly?_____ What type of activity?_____

How many ounces of water do you drink daily?_____ What type? RO Tap Spring Distilled

Which meals daily eaten? Breakfast Lunch Supper How many eliminations per day?_____

How many digestive enzymes daily?_____ How many breathing exercises daily?_____

How much of the following do you consume? (example, 1D = once daily, 3M = 3 times monthly)

Soda pop_____	Coffee_____	Smoking_____	Alcoholic Bev_____
Fast food_____	Milk_____	White Flour_____	Sugar usage_____
Raw fruit_____	Meat_____	Raw Veggies_____	Whole Grains_____

What types of food do you crave? Salty Chocolate Sweets Breads Other_____

What are your favorite foods?_____

How much daily energy (1 = lowest energy level; 10 = highest energy level) do you have?_____

What surgeries have you had and when? Circle NONE if applicable._____

_____

How many hours of TV do you watch? Daily_____ Weekly_____

How many hours of spiritual enrichment each week? (Bible, prayer, church, etc.)_____

How many hours a week do you spend with family/friends?_____

How many hours of sleep do you get each night?_____ How many hours do you need?_____

What kind of prescription medication do you take? Circle NONE if applicable._____

_____

Would you like to receive our natural health newsletter? YES NO

Who referred you for your appointment today?_____

I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food supplements and herbs as a guide to general good health and this is a personal ministry and spiritual counseling.

I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purposes or treatment procedures. I am not on this visit or any subsequent visit an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

The services performed here are at all times restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health and do not involve the diagnosing, treatment, or prescribing of remedies for disease.

Signature_____ Date_____

Current Complaint History

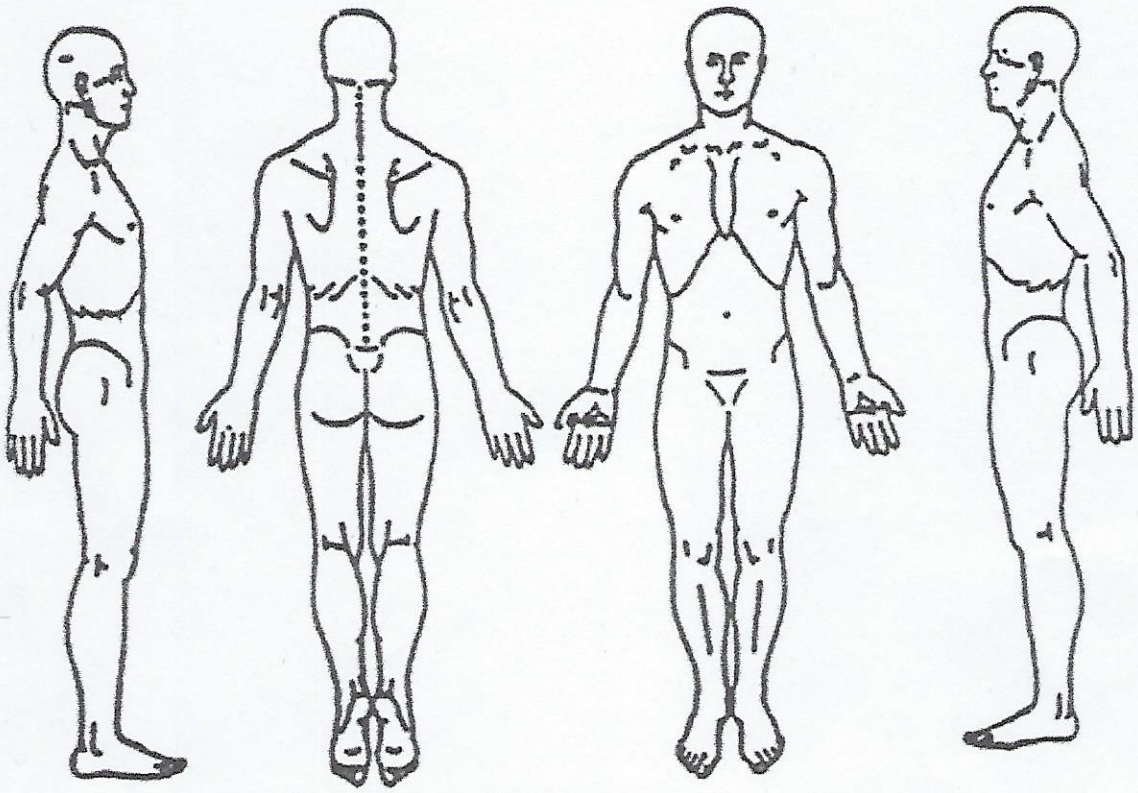
What brings you into the office? _____

_____

_____

Have you ever had similar issues? _____ Explain: _____

Please indicate below where you are experiencing concerns.



Place an "X" on the line below to indicate the level of the problem.

(No Symptoms) 1——————————————————————————10 (Extreme Symptoms)

What have you done or used to get relief? _____

_____

What are your expectations for this visit? _____

_____

List any vitamins, herbs, or supplements you take. _____

_____

TOTAL- BODY SYMPTOM QUESTIONNAIRE

NAME: _____ DATE: _____

The Total-Body Symptom Questionnaire identifies symptoms that help identify the underlying causes of illness, and helps you track your progress over time. Answer the Following Questions as they apply to the patient in the last 90 Days.

POINT SCALE

0 = Never or almost never have symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect if not severe
4 = Frequently have it, effect is severe

KEY TO QUESTIONNAIRE

Add individual score and total each group. Add each group score and give a total score. Total scores higher than 70 or high scores in one particular area may be indicative of an underlying healthcare condition that requires more intense treatment.

Optimal = Less than 10 Mild = 10-40 Moderate = 40-70 Severe = Over 70

IMMUNE
___ Fatigue/ sluggishness
___ Mild fever
___ Repeated infections
___ Restlessness
___ Diagnosed with chronic infection
If yes, which type? _____

Total _____

ADRENAL
___ Chronic fatigue
___ Loss appetite
___ Muscle weakness
___ Weight gain

Total _____

BLADDER/KIDNEYS
___ Painful urination
___ Frequent urination
___ Blood in urine

Total _____

BLOOD SUGAR/ CARDIOVASCULAR
___ Irregular or skipped heartbeat
___ Shortness of breath w/walking
___ Increased thirst
___ Frequent urination
___ Diagnosed with elevated cholesterol
___ Diagnosed with elevated blood lipids
___ Diagnosed with abnormal blood sugar
___ Diagnosed with elevated blood pressure

Total _____

WOMEN ONLY (Hormones)
___ Night sweats
___ Hot flashes
___ Weight gain/ bloating
___ Painful intercourse
___ Frequent urinary tract infections
___ Irregular cycles/ Infertility

Total _____

GASTROINTESTINAL
___ Flatulence, gas, abdominal cramping
___ Nausea/vomiting
___ Loose stools/diarrhea
___ Constipation
___ Blood in stool
___ Food insensitivity symptoms
___ Heartburn

Total _____

SKIN
___ Dry or cracked skin
___ Rashes, hives, or itchy skin
___ Acne or breakouts
___ Excessive sweating, night sweats

Total _____

JOINTS/MUSCLES
___ Muscle pain
___ Join pain or stiffness
___ Fracture, break, or strain

Total _____

MENTAL WELL-BEING
___ Ongoing fatigue
___ Anxiety
___ Hyperactivity
___ Sleep disturbance
___ Depression
___ Mood swings
___ Difficult remembering things

Total _____

MAN ONLY (Hormones)
___ Loss of libido
___ Lack of desire to be intimate
___ Loss of motivation
___ Flat mood
___ Diminished well-being
___ Weight gain
___ Low energy
___ Loss of muscle tone

Total _____

UPPER RESPIRATORY
___ Nasal congestion
___ Sinus infection/congestion
___ Upper respiratory allergy symptoms
___ Sore throat/cough
___ Shortness of breath
___ Asthma
___ Chest pain

Total _____

EARS
___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Total _____

EYES
___ Watery or itchy eyes
___ Blurry vision
___ Dark circles/puffy/bags under eyes

Total _____

HEAD
___ Headaches
___ Migraine
___ Faintness
___ Dizziness

Total _____

OTHER
Weight gain
lbs. ___ in ___ months/yrs. _____

Weight loss
lbs. ___ in ___ months/yrs. _____

TOTAL SCORE _____

Symptoms and Areas of Concern (check all that apply)

- [ ] Acne
- [ ] ADD/ADHD
- [ ] Adrenal Glands
- [ ] Allergies
- [ ] Alzheimer's Disease
- [ ] Anemia
- [ ] Anger
- [ ] Anxiety
- [ ] Appetite
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Bad Breath
- [ ] Bed Wetting
- [ ] Bell's Palsy
- [ ] Bites
- [ ] Bladder
- [ ] Blood Pressure - High
- [ ] Blood Pressure - Low
- [ ] Boils
- [ ] Bones
- [ ] Breathing
- [ ] Bronchitis
- [ ] Bruises
- [ ] Burns
- [ ] Cancer
- [ ] Candida
- [ ] Canker Sores
- [ ] Carpal Tunnel
- [ ] Cataracts
- [ ] Chest Congestion
- [ ] Chest Pain
- [ ] Cholesterol
- [ ] Circulation
- [ ] Cold - Common
- [ ] Cold - Temperature
- [ ] Colic
- [ ] Colon
- [ ] Constipation
- [ ] Cough
- [ ] Cravings
- [ ] Dandruff
- [ ] Depression
- [ ] Diabetes
- [ ] Diarrhea
- [ ] Digestion
- [ ] Dizzy Spells
- [ ] Ear Infection
- [ ] Ear Ringing
- [ ] Edema
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Eyesight
- [ ] Fatigue
- [ ] Fever
- [ ] Flu
- [ ] Gallstones
- [ ] Gangrene
- [ ] Gas
- [ ] Gout
- [ ] Gums
- [ ] Hair Issues
- [ ] Headache
- [ ] Heart Issues
- [ ] Heartburn
- [ ] Hemorrhoids
- [ ] Herpes
- [ ] Hiatal Hernia
- [ ] Hives
- [ ] Hormones
- [ ] Hyperactive
- [ ] Hypertension
- [ ] Hyperthyroidism
- [ ] Hypoglycemia
- [ ] Impotence
- [ ] Incontinence
- [ ] Indigestion
- [ ] Insomnia
- [ ] Joint Pain
- [ ] Kidney Issues
- [ ] Kidney Stones
- [ ] Laryngitis
- [ ] Leprosy
- [ ] Leukemia
- [ ] Liver
- [ ] Lung Issues
- [ ] Lupus
- [ ] Lymph Glands
- [ ] Menopause
- [ ] Menstrual Cramps
- [ ] Migraines
- [ ] Mononucleosis
- [ ] Mucous
- [ ] Nails
- [ ] Nausea
- [ ] Nervousness
- [ ] Nose Bleeds
- [ ] Parasites
- [ ] Parkinson's Disease
- [ ] Perspiration
- [ ] PMS
- [ ] Pneumonia
- [ ] Polyps
- [ ] Pregnancy
- [ ] Prostate
- [ ] Psoriasis
- [ ] Rash
- [ ] Reproductive
- [ ] Respiratory
- [ ] Rheumatism
- [ ] Ring worm
- [ ] Seizures
- [ ] Shingles
- [ ] Sinus
- [ ] Skin Issues
- [ ] Snoring
- [ ] Sore Throat
- [ ] Stomach
- [ ] Stress
- [ ] Stroke
- [ ] Sty
- [ ] Teething
- [ ] Tennis Elbow
- [ ] Tonsillitis
- [ ] Tumors
- [ ] Ulcers
- [ ] Urinary Infections
- [ ] Varicose Veins
- [ ] Vertigo
- [ ] Weight - Overweight
- [ ] Weight - Underweight
- [ ] Yeast Infections
- [ ] OTHER: