LIFESTYLE QUESTIONS

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____ Country: _____

Home Phone: _____ Cell: _____ Fax: _____

Email:_____ Referred by:_____

Date of Birth: M/____D/ ____Year/_____ Place of Birth:_____ Time of Birth:___

***Do you have a Pacemaker? yes / no**

***Are you pregnant? yes / no**

*Are you sensitive to electricity? yes / no

*Rate how you feel today on scale of 1-10: _____

*Personal stress level (1-10 max.):_____

*Your positivity level (1 negative-10 positive):_____

Number of organs removed: _____

Number of prescription drugs currently used: _____

Amount you smoke/day: _____

Number of steroid type drugs used in last year: _____

Number of metal amalgam fillings-
(Current or present during last year): _____

Number of street drugs used in last month: _____

Number of known allergies: _____

Number of emotional mental factors: _____
(Depression, anger, anxiety, worry, etc.)

Responsibility for your health (1-10 max):_____

Amount of fat in diet (20-low,30-med,40-high):_____
(Include processed foods)

Do you take vitamins daily? _____

Number of sugar type products/day: _____
(On average) Include soft drinks, ice cream etc.

Number of exercise sessions/week: _____
(15 minutes or more)

Number of alcoholic drinks weekly (average): ____

Number of cups of coffee, tea/day: _____
(Average caffeine intake)

Number of extreme toxic exposures: _____
(Radiation, insecticides, chemicals)

Number of major infections: ____
(Past and present)

Number of major injuries in past: _____
(Major car accidents, falls, etc.)

Number of glasses of water per day: _____

Are you comfortable with your weight? If not, how many lbs. over or under weight? _____

AGREEMENT FOR SERVICES AT COMPLETE HEALTH

The services offered by **Complete Health** are for **Biofeedback and Bioenergetic stress reduction.** These disciplines are not connected with traditional medicine as practiced by western medical doctors and hospitals. They are entirely separate disciplines concerned with the correction of energy fields and the balancing the BioElectric frequencies of the human system. Traditional medicine is based on BioChemistry. Quantum biofeedback is based on BioPhysics and quantum Physics.

Complete Health's Biofeedback technology or personnel do not diagnose, treat, prescribe or claim to cure any disease. Clients are advised that they should consult their own medical practitioners and medical professionals for the diagnosis, care, treatment or cure of any health concerns. All information discussed with your biofeedback practitioner during your session is confidential.

However, it is the intent of Complete Health to promote self-healing through Acupuncture, information, stress reduction, biofeedback frequencies, emotional support, and nutritional, homeopathic or herbal supplements as determined by Teresa Rispoli, LAc, DCN

I agree to undergo BioEnergetic therapy at my own risk. I further indemnify and hold harmless Complete Health and Teresa Rispoli, LAc., DCN and/or/her affiliates, officers, as well as, any successors, assigns and executors, administrators, personal representatives, employees and heirs from any and all results of biofeedback or any other modality I receive from Complete Health including The LIFE SYSTEM.

This agreement shall be unlimited as to amount of duration, and it shall be binding upon and inure to the benefit of the parties, their successors, assigns and personal agents and representatives. The procedures of this service may require the touching of the client's body by the practitioner, but only for practical reasons to connect the harness.

Your signature below constitutes your acknowledgment that 1) You have read and agree to the foregoing; 2) that the procedure set forth above has been adequately explained to you by this provider, and 3) that you authorize and consent to the performance of the foregoing stress reduction procedures.

_____ _____

Signature **Date**

_____

Print Name

_____

Witness Signature

Complete Health 28247 Agoura Rd. Agoura Hills, CA 91301

BIOFEEDBACK INFORMED CONSENT AGREEMENT

BACKGROUND: This office is using a computer-assisted biofeedback system designed to help identify particular agents associated with stress reactions and other agents which reduce those reactions, through the use of galvanic skin response.

PROCEEDURE: The procedure is totally non-invasive (the skin is not pierced). This pre-diagnostic method includes the application of an electronic device of low voltage to measure skin resistance at various points located primarily on hands and feet. The unit is registered with the FDA as a class II instrument.

RESULTS/BENITITS: By using the additional information provided by this procedure, it is possible that your doctor will be able to reduce the time, costs and risks associated with the typical trial and error process required to arrive at the correct course of therapy for you.

ALTERNATIVE PROCEDURES: This procedure is a biofeedback examination and, as such, is intended to be used prior, or in addition to established diagnostic procedures. It is not intended to be used as an alternative when other means are available or desired. This procedure does not measure, identify or threat disease. It identifies frequencies which are interpreted as being negative for the body as a whole. These negative frequencies are then neutralized by positive biofeedback frequencies or the use of homeopathic tinctures. The presence of a frequency does not indicate the absence of a disease. Homeopathic remedies are designed to repetorize, which means to balance the whole person, rather than to treat a specific disease.

I have fully read and understand: the above information with reference to my responsibilities and rights, and hereby consent to the use of the skin resistance measurement device for the purpose of my evaluation.

PURPOSE OF YOUR VISIT: By signing this form you agree your objective is to advance your own personal health, and that you are not here on behalf of any governmental or investigative body.

DATE: _____

NAME OF PATIENT: _____
FIRST MIDDLE LAST

IF PATIENT IS A MINOR:
NAME OF GUARDIAN: _____
(PLEASE PRINT)

SIGNATURE: _____
PATIENT OR PATIENT'S GUARDIAN

HIPAA Compliance and Consent Form

The Undersigned:

Patient:_____

Born on: _____

Resident of: _____

On April 14th, 2003 the new federal Health Insurance Portability and Accountability Act (HIPAA or "the Act") became effective. The stated purpose of the Act is to protect the confidentiality and security of your health information through different privacy standards.

Our facility will do everything in its power to abide by the HIPAA regulations and respect the **privacy of your name and your medical information**. **We agree to refrain from using your name as a referral without your express written consent**. We will use our best efforts to keep your name and your medical information confidential.

We occasionally e-mail out appointment reminders, newsletters, and special offers to our clients. If you consent to receiving these communications by e-mail, please indicate by signing the consent form below. Please let us know if you have any questions. Thank you.

I have read and understand this HIPAA compliance and consent form. I hereby give my consent to the facility to send me appointment reminders, greeting cards, special offers, and newsletters in the mail. I do **not** give my consent to having my names used as a reference unless otherwise indicated.

_____ _____

Client Signature **Date**

_____ _____

Witness **Date**