New Client Intake Form

CONTACT INFORMATION TODAY'S DATE: ___/___/___

Name:_____ Date of Birth:___/___/___ Biological Sex: ☐Male ☐Female

Street Address:_____ City:_____ State:_____ Zip:_____

Primary Phone Number: _____ ☐ *Check Here if this number can receive text messages*

Email Address: _____ Occupation:_____

Emergency Contact: Name_____ Phone_____ Relationship_____

HEALTH BACKGROUND

Health & Wellness Providers seen in the last year (please check all that apply): ☐Medical Doctor ☐Chiropractor ☐Acupuncturist ☐Dentist ☐Optometrist ☐Naturopath/Natural Medicine ☐Physical Therapist ☐Psychotherapist ☐Energy Practitioner ☐Other_____

Number of medical office visits in the last year: _____ Number of hospitalizations: _____

Please select ALL implants that you may have ☐Pace Maker ☐Implantable cardioverter defibrillator (ICD) ☐Insulin pump/ glucose monitor ☐Pressure sensor in vascular system ☐Cochlear Implant ☐Neurostimulator ☐Intraocular lens ☐Artificial joints ☐Breast or other cosmetic implants ☐Hearing Aids ☐Intrauterine contraceptive devices (IUD) ☐Other bioelectronic device(s):_____

Major Surgeries (please list with approximate date): _____

_____

Significant Traumas (please list with approximate date):_____

_____

Known Allergies: _____

Weekly Exercise Habits (check all that apply): ☐**Low Activity** (less than 60 minutes per week) ☐**Moderate Activity** (Between 60 – 120 minutes per week) ☐**High Activity** (>120 minutes per week) ☐Weight Lifting/Resistance Training ☐Walking/Running ☐Biking ☐Dance/ Movement ☐Martial Arts/ Gymnastics ☐Yoga/ Pilates ☐Qi Gong ☐Other

Please describe your typical diet/eating habits: _____

_____

_____

Are you currently dissatisfied with any of the following social aspects of your life: ☐Work/Income ☐Education ☐Home ☐Marital/Love Relationship ☐Friendships/ Sense of Community & Belonging ☐Other:_____

Females

Are you currently pregnant? ☐Yes ☐No ☐Unsure ☐Not Applicable (male)

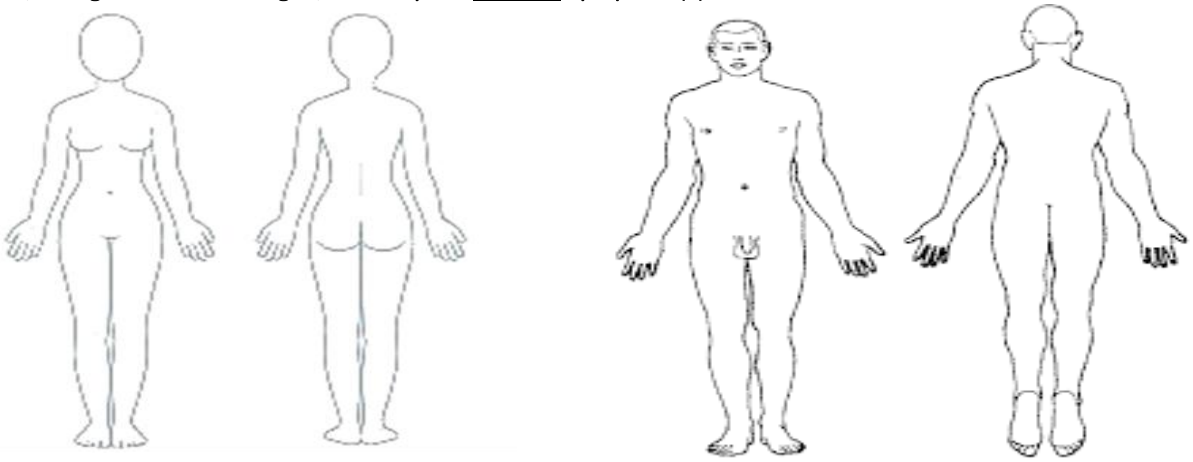
Age of first period _____ Date of Last PAP___/___/___ Date of Last Mammogram ___/___/___

1st day of last period ___/___/___ Days between periods _____ Days of Bleeding _____ Date of Menopause Onset_____

Please check any conditions that you have had in the past or current. P=past C=current

P C Condition	P C Condition	P C Condition	P C Condition
☐☐ Pain in extremities	☐☐ Grinding teeth/jaw pain	☐☐ Large weight gain/loss	☐☐ Desiring drugs/alcohol
☐☐ Cold hands or feet	☐☐ Excessive thirst	☐☐ Craving sweets/sugar	☐☐ Overly emotional
☐☐ Swollen ankles or feet	☐☐ Excessive sweating/urination	☐☐ Craving salty foods	☐☐ Bored/Lonely
☐☐ Restless legs	☐☐ Racing heart/Breathing	☐☐ Lethargy/fatigue	☐☐ Thoughts of harm
☐☐ Neck/shoulder tension	☐☐ Dizziness/light headed	☐☐ Sleep difficulties	☐☐ Fever/Chills
☐☐ Abdominal issues	☐☐ Sinus/Allergy Issues	☐☐ Low libido	☐☐ Vision problems

Please indicate, using the below images, where your <u>current</u> symptom(s) are located.



MAJOR HEALTH COMPLAINTS

Please list up to six (6) major health concerns that you would like to discuss, in order of significance to you.

1. ☐ _____ 2. ☐ _____
3. ☐ _____ 4. ☐ _____
5. ☐ _____ 6. ☐ _____

Health Concern #...	Date issue began	Frequency	Known Triggers	Describe Symptoms	Attempted Treatments	What Makes Issue Worse	What Makes Issue Better	Other family members that experience these issues?
Example	*Jan. 2014*	*Weekly*	*Too much Computer Work*	*Sharp pain/ Achy*	*Natural salves/ stretching*	*Sitting longer/ laying on side*	*Stretching with knee to chest*	*Mom*
1								
2								
3								
4								
5								
6								

Have you ever been diagnosed with any of the following health problems? Check all that apply.

☐Epilepsy or Seizures	☐Schizophrenia	☐Bi-Polar	☐Depression
☐Anxiety or Panic Attacks	☐Attention Deficit Disorder	☐Obsessive-Compulsive	☐HIV/AIDS/STD
☐Osteoarthritis	☐Fibromyalgia	☐Lou Gehrig's Disease (ALS)	☐Headaches (with aura)
☐Rheumatoid Arthritis	☐Cancer or Tumors	☐Multiple Sclerosis	☐Tuberculosis
☐Polio or Mononucleosis	☐Pneumonia or Bronchitis	☐Stroke or ATI	☐High/ Low Blood Pressure
☐Raynaud's Disease	☐Skin Disorder	☐Thyroid Disorder	☐Diabetes/ Hypoglycemia
☐Gastrointestinal Disease	☐Spleen or Lymphatic Disorder	☐Gall Bladder Stones/Disorder	☐Kidney Stones/Disorder
☐Urinary/Bladder Infection	☐Liver Disease/ Hepatitis	☐Lung/ Respiratory Disorder	☐Coronary /Heart Disease
☐Shingles (Herpes Zoster)	☐Peripheral Neuropathy	☐Frozen Shoulder/Tennis Elbow	☐Carpal Tunnel Syndrome
☐Parkinsons	☐Alzheimer's (early onset)	☐Eye Disease	☐PCOS/Endometriosis/PMS
☐Infertility/Perimenopause	☐Pre-menstrual Syndrome	☐Concussion	☐Bone Break/Fracture/Sprain
☐Muscle Spasms/Tremors	☐COVID-19	☐Chronic Fatigue Syndrome	☐Other:_____

For any items checked above, please feel free to provide additional details below including date of diagnosis, current status, treatment plans, etc. _____

_____

_____

_____

Please list current medications, including supplements and herbal remedies below: _____

_____

_____

_____

Please indicate whether you practice any of the below activities by checking the box and include frequency.

Activity	Yes	Never	Once or Twice	Yearly	Monthly	Weekly	Daily
Breathwork	☐	☐	☐	☐	☐	☐	☐
Guided Meditation	☐	☐	☐	☐	☐	☐	☐
Mindfulness	☐	☐	☐	☐	☐	☐	☐
Binaural Beats/ Sound Healing	☐	☐	☐	☐	☐	☐	☐
Other Frequency/Microcurrent Treatment	☐	☐	☐	☐	☐	☐	☐
Autogenic Training	☐	☐	☐	☐	☐	☐	☐
Biofeedback	☐	☐	☐	☐	☐	☐	☐
Intermittent Fasting/Extended Fasts	☐	☐	☐	☐	☐	☐	☐
Specific Diet Practices	☐	☐	☐	☐	☐	☐	☐
Cold Thermogenesis	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐

In addition to addressing the Major Health Concerns listed, do you have any other goals that you would like to focus on?

☐ Rediscover peacefulness/joy ☐ Establish physical well-being via ☐Nutrition or ☐Physical Movement

☐ Enhance wellness education ☐ Establish/deepen spiritual practices ☐ Achieve goals: _____

☐ Other:_____

Please acknowledge which services you are comfortable receiving by checking the respective box.

☐ Wellness Evaluation	☐ Microcurrent Therapy – Ear	☐ Sound Healing/ Toning/ Mantras/Mudras
☐ Auricular Qi Gong/ Massage	☐ Microcurrent Therapy – Body	☐ Breathwork/Relaxation/ Autogenic Training
☐ Reiki (Hands-ON or OFF)	☐ Essential Oils – Topically	☐ Cupping
☐ Bodywork & Acupressure	☐ Herbs/Oils - Aroma & Energetics	☐ Gua Sha

PLEASE CHECK IF YOU EXPERIENCE ANY OF THE FOLLOWING ON A REGULAR BASIS:

Head, Eyes, Ears, Nose, Throat

☐Glasses ☐Eye Strain/Pain ☐Red Eyes ☐Dry/Itchy Eyes ☐Bumps on Eyes ☐Night Blindness
☐Spots In Vision ☐Halos in Vision ☐Blurred Vision ☐Teeth Grinding ☐Many Cavities ☐Mouth/Lip Sores
☐Bleeding Gums ☐Dental Work ☐TMJ ☐Headaches ☐Gum Problems ☐Earaches
☐Enlarged Thyroid ☐Migraines ☐Ringing In Ears ☐Throat Tickle ☐Concussions ☐Nosebleeds
☐Hearing Loss ☐Throat Drainage ☐Excessive Saliva ☐Facial Pain ☐Lump In Throat ☐Heavy Head
☐ ☐Sore Throat ☐Swollen Glands ☐Sinus Problem ☐Sinus Drainage ☐Facial Numbness

Respiratory

☐Difficulty Breathing ☐Tight Chest ☐Pleurisy ☐Shortness of Breath ☐Asthma ☐Phlegm/Congestion
☐Rattling with Breath ☐Pneumonia ☐Chronic Cough ☐Acute Cough ☐Wheezy ☐Can't Sleep Lying Down

Cardiovascular

☐Hypertension (High Blood Pressure) ☐Chest Pain ☐Rapid Heart Rate ☐Palpitations ☐Irregular Heart Rate
☐Hypotension (Low Blood Pressure) ☐Fainting ☐Slow Heart Rate ☐Blood Clots ☐Edema (Swelling)

Gastrointestinal

☐Nausea ☐Diarrhea ☐Dark Colored Stool ☐Vomiting ☐Constipation ☐Light Colored Stool
☐Acid Regurgitation/Reflux ☐Use Laxatives ☐Mucus in Stools ☐Gas/Flatulence ☐Use Antacids
☐Blood in Stools ☐Hemorrhoids ☐Hiccups ☐Use Fiber ☐Rectal Pain/Itching
☐Bloating ☐Use Digestive Enzymes ☐Fissures ☐Bad Breath ☐Intestinal Pain
☐Vomiting Blood ☐Poor Appetite ☐Bowel Movement < 1X/Day ☐Bowel Movement > 1X/Day

Genito-Urinary

☐Pain with Urination ☐Bed Wetting ☐Impotence ☐Frequent Urination ☐Incomplete Urination
☐Dribble with Urination ☐Wake to Urinate ☐Urgent Urination ☐Frequent UTIs ☐Nocturnal Emissions
☐Kidney Stones ☐Blood in Urine ☐Increased Libido ☐Decreased Libido ☐Premature Ejaculation

Musculo-Skeletal

☐Muscle Weakness ☐Muscle Spasms ☐Muscle Cramps ☐Muscle Atrophy ☐Falls ☐Limited Range of Motion
☐Chronic Pain ☐Acute Pain ☐General Aches ☐Joint Pain ☐Arthritis ☐Joint Instability

Neurological

☐Seizures/ Epilepsy ☐Fainting/Syncope ☐Dizziness ☐Vertigo ☐Drowsiness ☐Loss of Balance
☐Poor Memory ☐Tremor ☐Convulsions ☐Paralysis ☐Stroke/CVA/TIA ☐Numbness

Neurophysiological

☐Depression ☐Worry Easily – Anxious ☐Abuse Survivor ☐Irritable ☐Unresolved Grief ☐Receiving Counseling
☐Easily Stressed ☐Frightened Easily ☐Received Counseling ☐Easily Frustrated ☐Numbness ☐Poor Memory

Skin and Hair

☐Rashes ☐Psoriasis ☐Hair Loss ☐Hives ☐Acne ☐Hair Changes ☐Ulcerations ☐Itching ☐Hair Breaking
☐Eczema ☐Dandruff ☐Thin/Slow Growing Nails ☐Fungal Infection ☐Skin Changes ☐Premature Graying

Vitality and Immune System

☐Frequent Colds ☐Chronic Mental Cloudiness ☐Slow Wound Healing ☐Frequent Flu ☐Low Energy
☐Lethargic ☐Tender/Achy All Over ☐Less Ability to Adapt

Gynecology ☐N/A

☐Currently Pregnant ☐Past Pregnancies #____ ☐Pre-Mature Births #___ ☐Miscarries #____ ☐Abortions #___
☐Decreased Libido ☐ Increased Libido ☐Hysterectomy ☐Excess Vaginal Discharge ☐PMS ☐Pain Before Menstruation
☐Pain During Menstruation ☐Pain After Menstruation ☐Vaginal Itching ☐Heavy Bleeding ☐Blood Clots
☐Spotting Between Cycles ☐Vaginal Sores ☐Vaginal Odor ☐Vaginal Dryness ☐Menopausal ☐Peri-Menopausal
☐Use HRT ☐Bone Density Changes ☐Breast Tenderness/Lumps ☐Lumpectomy ☐Mastectomy ☐Fibrocystic Breasts
Contraceptive Use: ☐None ☐Pill ☐Patch ☐Ring ☐IUD ☐Shot ☐Diaphragm/Condoms ☐Withdrawal ☐Other_____

ARRAY OF LIGHT

CONSENT FOR PROVIDED SERVICES

I. SERVICES

I, the Client, request that the Practitioner perform a Wellness Evaluation which may include use of bio-resonance non-linear analysis systems, nutrition scans, single point testing, meridian assessment, biofeedback analysis, visual observation, and manual palpation of pulse and body points. In addition to the Wellness Evaluation, I confirm that I understand the services and associated risks and consent to receive services by the Practitioner for the purpose of reducing stress, improving well-being, and/or restoring and maintaining homeostasis.

II. CONSENT

a. I understand that the Practitioner is not licensed in any State due to the nature of the unlicensed natural medicine field. As such, the Practitioner holds doctorate degrees in Natural Medicine, Bioenergetic Medicine, and Sacred Medicine, is certified in AuriculoMedicine and Biofeedback by the Institute of Bioenergetic Medicine and by the International Organization of Bioenergetic Medicine Practitioners, is a Ceremonial Minister and Officiant as licensed by the First Nations Ministry with membership in the Medicine Wheel Society of First Nations, holds a Bachelor of Arts in Philosophy and Religion, a Master's of Business Administration with a concentration in energy management, has a certification in Reiki from the Wu Wei School of Reiki along with certificates in Energy Psychotherapy and Yoga RYT-200. Practitioner's learned knowledge may be researched, learned, and retained by the general population;

b. I understand that I, as a human, have the Divine right of all Beings to inherently know, learn, and practice self-mastery of well-being; that I have the US Constitutional rights to freely engage in contracts, freely speak, and freely exercise individually chosen religious beliefs including those foundational to my overall wellbeing;

c. I understand that I am under no obligation to receive nor continue services nor act on the general recommendations that may be provided by the Practitioner and may end Services at any time;

d. I understand that my health and wellness are my own responsibility and I take full accountability for any and all decisions made and outcomes that may incur as a direct, or indirect, result of receiving natural medicine Services and recommendations from Array of Light Wellness Studio, LLC and its Practitioners;

e. I understand that my improved wellness and homeostasis is the goal of the Practitioner and, while there exists many modalities for attaining and maintaining homeostasis, some may work for me while others do not;

f. I understand that the Practitioner utilizes a variety of modalities to identify the presence of imbalances, and while often thorough, may not identify all points of stress existing within a client's field of being.

g. I understand that all services and recommendations shared by the Practitioner are for the purposes of reducing stress, enhancing wellbeing and restoring and maintaining homeostasis. The products and statements provided on the website, blog, any emails received as a result of subscribing to the Practitioner eNewsletter, and any information written or verbally expressed as a result of contacting the Practitioner are educational and informational resources for people seeking information on how to live a balanced lifestyle and restore homeostasis; these have not been evaluated by the Food and Drug Administration. Provided services, products and statements are not intended to diagnose, treat, cure, nor prevent any disease. As with all health & wellness information, always consult your professional healthcare provider before beginning any new treatment or program as these are not a substitute for regular western medical care.

_____	_____	_____
Client Name	Client Signature	Date

III. DISPUTES

If any dispute arises under this Agreement, the Practitioner and Client shall negotiate in good faith to settle such dispute. If the parties cannot resolve such disputes themselves, then either party may submit the dispute to mediation by a mediator approved by both parties. If the parties cannot agree with any mediator or, if either party does not wish to abide by any decision of the mediator, they shall submit the dispute to arbitration by any mutually acceptable arbitrator, or the American Arbitration Association (AAA). The costs of the arbitration proceeding shall be borne according to the decision of the arbitrator, who may apportion costs equally or in accordance with any finding of fault or lack of good faith of either party. If either party does not wish to abide by any decision of the arbitrator, they shall submit the dispute to litigation. The jurisdiction for any dispute shall be administered in the County of Gaston, State of North Carolina.

_____	_____	_____	_____
Client Signature	Date	Practitioner Signature	Date

ARRAY OF LIGHT

IV. NINTH AMENDMENT DECLARATION

ARTICLE IX, U.S. CONSTITUTION

"The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the People."

Under the Ninth Amendment to the Constitution of the United States of America, I retain the right to freedom of choice in health care and wellness. This includes the right to choose my diet, and to obtain, purchase, and use any therapy, regimen, modality, remedy, or product recommended by the Practitioner of my choice.

The enumeration in this declaration of these rights shall not be construed to deny or disparage other rights retained by me, or my right to amend this declaration at any time.

CONSTRUCTIVE NOTICE

Notice is hereby given to any person who receives a copy of this Declaration and who, acting under the color of law, intentionally interferes with the free exercise of the rights retained by me under the Ninth Amendment, as enumerated in this Declaration, that they may be in violation of my civil and constitutional rights, Title 42, U.S.C. 1983 et seq. and Title 18, Section 241

_____ _____
Client Name Date

_____
Client Signature

_____ _____
Practitioner Name Date

_____
Practitioner Signature

**Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.* (R.S. § 1979; Pub. L. 96–170, § 1, Dec. 29, 1979, 93 Stat. 1284; Pub. L. 104–317, title III, § 309(c), Oct. 19, 1996, 110 Stat. 3853.)