Press Tab key to advance to each field

Quantum Waves
1320 Van Beurden Dr. #102
Los Osos, CA 93402 • 805-704-3599

Name:

Address:

Date of Birth: Time of birth: Place of birth:

Home phone: Cell Phone: Email:

General complaint:

Stress Assessment - ***Please consider and answer questions in relation to stress***

No. of organs removed e.g.; tonsils, appendix, etc. *count ovaries individually
No. of prescription or over the counter medications taken daily
No. of times a day you smoke or chew tobacco
No. of steroid type drugs taken in past year, include inhalers
No. of silver amalgam type dental fillings current in teeth
No. of street drugs used each month
No. of known allergies
No. of persistent thoughts by category e.g.; work, relationship, health issues, etc
On a scale of 1-100% how much do you feel it is your responsibility for your health %
Amount of fat in your diet by % (average American diet is at 40%) %
Rate overall stress level (1–10 with 10 highest)
No. of sugar filled products you consume daily e.g.; candy bar, café mocha, etc
No. of times a week you exercise 20 minutes or more
No. of alcoholic drinks consumed daily, or average out for week
No. of caffeine products consumed daily e.g.; coffee, tea, Red Bull, etc.
No. of toxic exposures e.g.; CT scan, chemotherapy, radiation therapy,
No. of past injuries emotional & physical – include surgeries
No. of past major infections that required hospitalization or long term medication
No. of glasses of pure water you drink on average per day
Do you feel you are overweight? If so, by how much?
Do you wear a pacemaker? ☐ Yes ☒ No Are you pregnant ☐ Yes ☒ No
Have you ever had electro-shock therapy? ☐ Yes ☒ No

I understand that the attending practitioner is not an allopathic doctor (MD), nor does she portray herself to be but is providing me with biofeedback services. I understand that the services provided identify energetic imbalances. Procedures include stress reduction protocols and biofeedback. I fully understand that the attending practitioner does not offer allopathic drugs, surgery, chemical stimulants or any other conventional treatments. In addition, I will not receive a diagnosis, treatment or prescription for any disease, condition or illness, or have any act performed on me that would constitute the practice of medicine for which a license is required. I have solicited the practitioner'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. I am fully aware and release the practitioner to do biofeedback testing, wellness consultation and 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.

Signature of client - (parent for minor) Date