Information provided herein by you, the client, is confidential to the QEST practitioner working with you. This information is used only to form the base point of how you are feeling today, and is not used to diagnose.

CLIENT INTAKE FORM

TODAY'S DATE_____

NAME_____

CELL PHONE_____

HOME PHONE_____

ADDRESS_____ CIRCLE: married widowed single divorced

CITY_____STATE_____ZIP_____ SPOUSE'S NAME_____

REFERRED BY_____

DATE OF BIRTH_____ AGE_____ IF CHILD, LIST PARENTS NAMES_____

E-MAIL ADDRESS_____ OCCUPATION_____

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Please use page four or back of page if more space is needed

1. When you were born, was it a difficult birth? **Y N** Very rapid birth? **Y N** C-section? **Y N** Forceps? **Y N** Do you happen to know your approximate birth weight? **Y**, it was ____lb. **N**
Comments:

2. Have you ever had blows to the head? Need **not** have caused unconsciousness. Ex.: Fall from a bicycle or downstairs, car or sports accident, object hitting head, falling off bed or being dropped as a baby, etc.) **Y N** Was a concussion diagnosed? **Y N** If yes, please list age(s) or year(s) and **describe what happened**. Describe any problems experienced afterward (if you remember).

3. Have you ever experienced a "whiplash"? **Y N** Have you ever been in an auto or other accident when a whiplash was *not* diagnosed? **Y N** If yes, please write what happened and what you experienced afterward.

4. Have you ever had any fractures (broken bones), sprains, or other sports or auto accidents? **Y N** If so, please list with appropriate date(s) or age(s).

5. Surgeries? **Y N** Please list, with date(s) or age(s).

6. Have you ever experienced chiropractic manipulation? **Y N** Was for (circle): neck upper or mid back lower back other Are you currently receiving adjustments? **Y N**

7. Are you taking any medication? **Y N** Under doctor's care for any reason? **Y N** If so, please explain:

8. Are you receiving any other kinds of healing modalities? **Y N** Please list.

9. Describe your diet. (*Check the one(s) that best describe your eating pattern and give details in the space below.*
   __ heavy meat (all kinds)
   __ light meat (all kinds)
   __ eat chicken & fish only
   __vegetarian (no meat)
   __ vegan (no meat, eggs, or milk products)
   How much water do you typically drink per day?_____ glasses
   List food in a typical day in the space below:

10. Please indicate which of the following you are taking…and if possible, which brands:
    __ vitamins
    __ minerals
    __ antioxidants
    __digestive enzymes
    __ homeopathic remedies
    __ herbs
    __ phytochemicals / carotenoids (from plants)
    __ other

11. Do you use any of the following…please indicate amounts and frequency:
    __ coffee
    __ "sodas"
    __ alcohol
    __ sugar
    __ tobacco
    __ recreational drugs

12. Do you have, or have you ever had: (*Please check all that apply)*

__ measles	__ bronchitis	__ hepatitis	__ pacemaker
__ mumps	__ pneumonia	__ HIV or AIDS	__ cancer __chemo __radiation
__ chicken pox	__ rheumatic fever	__ herpes	__ vaccinations
__ scarlet fever	__ asthma	__ heart attack	__ screws, metal plates

13. Do you have any allergies? **Y N**
    If yes, list types & explain: foods **Y N** airborne **Y N** environmental **Y N** cats **Y N**

    Do you have respiratory or sinus problems? **Y N** skin irritation **Y N** other?
    Do members of your family have any allergies? **Y N**

14. Number of pregnancies_____ Number of children_____ miscarriage(s) _____
    Type of contraception (if applicable) _____

15. Do you experience any of the following? **Don't just use a checkmark, but if present, please indicate:**
    "A"=Always "F"=Frequent "S"=Sometimes

__headaches	__hand pain	__diminished sense of taste
__stiff neck	__chest pain	__diminished sense of smell
__upper back pain	__pain in area of ribs	__equilibrium problems
__lower back pain	__pain in / behind sternum	__ringing in ears
__sciatica (pain down leg	__shoulder pain	__pain in ears
__hip pain	__knee pain	__dizziness
__ankle pain	__numbness / tingling fingers	__difficulty swallowing

__calf pain /leg pain
__foot pain
__heel pain
__elbow pain
__wrist pain
__tickling in throat
__periodontitis
__heartburn
__discomfort after eating
__intestinal gas
__abdominal distension
__intestinal pain
__diarrhea
__constipation
__alternating diarrhea & constipation
__rectal pain, fissures, bleeding
__hemorrhoids
__gallstones
__fatigue
__feeling of weakness
__light-headedness
__panic attacks
__anxiety
__feeling "on edge"
__feeling of impending doom
__depression
__hyperactivity
__attention deficit disorder
__learning difficulties
__drink diet soda

__TMJ / jaw pain
__arthritis (joint inflammation)
__osteoporosis
__sinus congestion
__dental problems / cavities
__trouble focusing / thinking
__"fuzzy" headedness
__trouble sleeping
__tachycardia / rapid heartbeat
__high blood pressure
__very low blood pressure
__high cholesterol—LDL
__high triglycerides
__kidney stones
__bladder infection
__frequency of urination
__wake up at night to urinate
__difficulty urinating
__burning / pain with urination
__impotence
__swollen glands
__sore throat
__acne or skin break-out
__psoriasis
__cysts
__tumors
__many moles / warts
__frequent colds / flu
__bruise easily
__ blood clots
__other:

__difficulty taking deep breath
__eye pain / dryness
__cough
__hungry right after eating
__stomach feels too full to e
__diminished immune response
__chronic fatigue
__anemia
__seizures
__PMS
__painful / abnormal periods
__painful abdomen
__parasites known / suspected
__irregular periods
__menopause
__TGIF
__diabetes diagnosed / suspected
__craving of sugar
__low blood sugar
__more tired after eating
__coordination problems
__accident-prone
__tired of questionnaires!
__chronic muscle pain
__joint pain
__frequent bloody nose
__osteoporosis
__other_____
__any reactions to prior energy work. Please describe here:
_____

16. Current exercise. Please list type and frequency of exercise. Example: walking—daily; running—3 x week, swimming—1 x week, weights—3 x week, Pilates, etc.

17. Have you played football, soccer or other sports? Have you grown up / worked on a farm / ranch? Have you had much experience riding horses / motorcycles?

18. Are you ambidextrous? Yes No If yes, please give some details.

19. **CURRENT CONCERNS:** (*Use next page and back of page, if needed!)*
What has prompted you to make this appointment? <u>What are you most concerned about right now?</u> Many people come to experience Quantum Energetics Structured Therapy because they want improved energy, enhanced immune response and sense of well-being, and/or early detection / prevention of problems. If this is true for you, please indicate. Note: no promises are made for QEST.

If you have specific problems, please list. For each, indicate when the problem started, any existing diagnosis and treatment. What has helped…or what has not helped? Please use next page as needed.

20. Do *you* have an idea about what is the cause of your problems—regardless of what diagnosis you may have?

21. **What would it mean to you** to be free of your problem(s) or…to have these problem(s) diminished? i.e., how would it enhance the quality of your life? What would you be able to do (and like to do) that you cannot do now? Please take time to answer. Thank you.

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To the best of my knowledge, I have listed all of my past and current conditions. (or my child's)
***Signature*_____ *date*_____