BIO-RESONANCE
LIFE FLOW

CLIENT INTAKE FORM

PART A: PERSONAL INFORMATION

FULL NAME: _____

ADDRESS: _____

E-MAIL: _____

PHONE: _____

BIRTHDATE: _____

PLACE OF BIRTH: _____

BLOOD TYPE (if you know it): _____

OCCUPATION: _____

FAMILY DOCTOR (name & number): _____

EMERGENCY CONTACT (name & number): _____

HOW DID YOU HEAR ABOUT US? _____

PART B: HEALTH HISTORY & CURRENT CONCERNS

1) Main reason for visit (what do you hope to get out of the analysis)**:**

2) How long has this been a concern? (days, weeks, months, years):

3) Previous treatment:

4) Are you presently under a doctor or practitioner's care? YES ☐ NO ☐

5) How would you rate your current state of health? (Please circle)
EXCELLENT ◯ GOOD ◉ FAIR ◯ POOR ◯

The following information will be used to help create scan parameters that best support your needs. Please answer to the best of your knowledge and advise of any changes (if any) during or between sessions.

6) Are the following health scenarios applicable to you (past and present)? Circle **YES** or **NO**; if **YES** please provide **details** and include **date(s)**.

Health Scenario	Applicable?	Date(s)	Details
Any metal in your body? (pins, screws, etc.)	Yes / No		
Ever had a stroke?	Yes / No		
Have a pacemaker?	Yes / No		
Have a known sensitivity to electromagnetism?	Yes / No		
Pregnant or possibly pregnant?	Yes / No		
Vascular or circulatory problems, cold extremities (cold hands/feet)?	Yes / No		
Infection or a history of recurring infections?	Yes / No		
Neoplasm/cancer, tumors, or degenerative dis-eases such as arthritis?	Yes / No		

Health Scenario	Applicable?	Date(s)	Details
Congenital disorder, hereditary or from birth?	Yes / No		
Endocrine/hormonal or glandular problems?	Yes / No		
Any skin issues? E.g., Eczema, Psoriasis	Yes / No		
Sensory problems (eyes, ears, taste, feeling, smell)?	Yes / No		
Adverse reaction to excess humidity, heat, cold, dryness, wind, or radiation?	Yes / No		
Known exposure to Insecticides, herbicides, industrial farm chemicals?	Yes / No		
Known exposure to heavy metals?	Yes / No		
Known exposure to radiation or disharmonious EMFs?	Yes / No		
Any organs removed (including teeth)? Please list.	Yes / No		
Any metal/silver dental fillings (include any removed within the last year)?	Yes / No		
Any known (or suspected) allergies or sensitivities? Please list.	Yes / No		
Any major injuries or surgeries (incl. emotional traumas) from the past? Include approx. year it happened?	Yes / No		
Any major infections where you were bedridden, feverish, or took antibiotics?	Yes / No		

Health Scenario	Applicable?	Date(s)	Details
Any steroid or antibiotic drugs used in the past 2 years?	Yes / No		
Any medications (including herbs) currently being used?	Yes / No		
Any dietary supplements being used?	Yes / No		

PART C: LIFESTYLE & EMOTIONAL BALANCE

Stress

- Personal stress level 0-10 (10 max):
- List main stress types (job, family, home, relatives, emotions, etc.):

Diet

- What taste are you usually drawn to? (sweet, salty, bitter, astringent, sour, bland):
- Number of sugar products per week (including soda, ice cream, breads, pastas etc.):
- Number of alcoholic drinks per week on average:
- Number of cups of coffee, tea, or caffeine products (chocolate) per day:
- What kind of diet/food do you eat?
- How many cups of water do you drink a day?
- Any dietary issues/restrictions (e.g., lactose or gluten intolerant)?

Exercise

- Number of exercise sessions per week, at 20 minutes or more:

Sleep

- How many hours of sleep do you get per night?
- Do you wake up feeling rested?

Emotions

- Do you have emotional challenges (e.g., depression, anxiety, sustained anger/rage)?
- Challenges with self-esteem?
- Tendency towards negative thinking?
- What feelings do you tend to experience most of the time?
- How do you self soothe or rebalance when you are upset?

Addictions

- Any addictions to drugs, alcohol, smoking, or others (if yes, please specify)?

Life Goals, Purpose & Fulfillment

- Have goals or hobbies that inspire and fulfill you?
- Have a good support network of positive family members or friends in your life?
- Are you living or close to living your ideal life?
- What would your friends and family say you are good at?
- What things do you most want to change or shift in your life?
- What gives you energy? Do you need quiet time alone or do you need to connect with others?
- What do you want less of in your life?

- What do you want more of in your life?
- What legacy do you wish to leave in the world?
- Are you living your soul purpose? If not, what is blocking you from doing so?
- Who are the people in your life that bring you the most joy and happiness?
- What are your top three goals for this year?

PART D: CONSENT FORM

- I provided information in the Client Intake Form which is true and to the best of my knowledge.
- I understand that the attending technician is not an allopathic practitioner (MD) and does not portray his/herself to be one. He or she is a wellness consultant and biofeedback/bio-resonance technician.
- I understand that the services provided by the attending technician are not allopathic, but are strictly behavioral, stress, or biofeedback in nature.
- Any reference to "patient" within this frequency balancing is solely due to the technical terminology used in bio-resonance and in no way implies that the client is a medical patient.
- I understand that the attending technician performs his/her services within the parameters of a natural health care and wellness system using biofeedback and stress reduction.
- I understand that the attending technician does not offer allopathic drugs, surgery, chemical stimulants, or any other conventional treatments. He/she does not diagnose, treat, or otherwise prescribe for any disease, condition, or illness, and that it is my wellness and stress parameters that are being measured.
- I have solicited the attending biofeedback technician'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 also exercise my free will in asking this business and technician for their opinion on items and situations which may expedite my good health; it is my choice should I accept to utilize or apply any of those ideas or suggestions at any time.
- If I desire any services not provided by the attending biofeedback technician, which is my prerogative, I understand that I should seek them elsewhere. A referral for such services can be arranged.
- I presently seek counsel, advice, opinions, biofeedback, or points of view and/or programs within the scope of the attending technician's wellness and stress reduction practice. I am fully aware and release the biofeedback technician to do biofeedback stress interpretations and frequency balancing.
- I understand that the services provided by the attending technician are not generally accepted and/or recommended by allopathic doctors (MD's) or other conventional

healthcare professionals. I realize that insurance payment may be possible but is highly unlikely.

- I understand that full payment is expected prior to the time of service.
- I understand that I must call and cancel an appointment at least 24 hours prior to my scheduled appointment time (for in person scans) if an appointment for said appointment was necessary. If I do not show up for a scheduled appointment, no refund will be issued.
- By signing below, I acknowledge that I have read and understood all parts of this waiver and that I have had the opportunity to ask any questions regarding all such procedures.
- The Food and Drug Administration has not evaluated these statements. This product is not intended to diagnose, treat, cure, or prevent any disease.

CONTRAINDICATIONS:

- Pacemakers
- Pregnancy

WITH CAUTION:

- Sensitivity to electromagnetism
- If you have metal in your body
- Epilepsy
- Stroke

Note: ***If you have any of the contraindications listed under "With Caution," please get in touch with me before booking. If you have a pacemaker or are pregnant, we cannot scan you at this time.***

I understand this service is not intended to be a substitute for my physician's medical advice, diagnosis, or treatment. Always consult with your medical treatment team (physician, psychiatrist, etc.) if you are suffering from a serious illness. We recommend that you combine our services with regular appointments with your primary medical practitioner.

You agree to the terms of this agreement and agree that your typed full name can be used as a digital representation of your signature to that fact.

Client Full Name (printed): _____

Client Signature (if page is printed): _____ Date: _____

Technician Full Name (printed): _____

Technician Signature: _____ Date: _____

Thank you!