Print Clear Form

absolute health
8360 E. Raintree Dr., Suite 135
Scottsdale, AZ 85260
(480) 991-9945 Phone
(480) 948-3204 Fax

Biofeedback – Health & History Assessment

Last Name _____ First Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Telephone: Home _____ Cell _____ Work _____

Date of Birth _____ Age _____ Email Address _____

Employer _____ Occupation _____

Emergency Contact Name _____Ph Number(s) _____Relation_____

How did you hear about Absolute Health? _____

Please circle: Female or Male Please circle: Married Divorced Separated Single Widowed

Name of spouse _____ Spouse's Date of Birth _____

Children's Names and Birth Dates:

_____ _____

_____ _____

_____ _____

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Please answer all questions below:

1.	# of organs removed (all teeth = 1)		11.	Personal Stress (Scale of 0-10) 0=NONE 10=MAX	
2.	# of prescription drugs		12.	# Sugar products consumed daily	
3.	# of cigarettes per day		13.	# Exercise sessions/wk - 20 min. each	
4.	# of steroid drugs		14.	# Alcoholic beverages consumed daily	
5.	# of metal dental fillings		15.	# Caffeine products consumed daily	
6.	# of street drugs		16.	# Extreme toxic exposures/year	
7.	# of allergies		17.	# Major traumatic injuries/life (Mental, emotional, physical, accidents, etc)	
8.	# of unresolved mental factors (grief, sadness, anger, greed, etc)		18.	# Major infections	
9.	I am responsible for my body (Scale of 0-10) 0=NO 10=YES		19.	# Glasses of 8 oz water daily	
10.	% of fat in diet (Average is 45%)		20.	# Pounds overweight (that YOU feel)	

Client History and Disclaimer

Please check if you have had or have been told by a medical doctor that you have any of the following:

☐ Aids / HIV
☐ Alcoholism
☐ Allergy Shots
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Breast Lumps
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fractures
☐ Glaucoma
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herniated Disc
☐ Herpes
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraine Headaches
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Prostate Problems
☐ Psychiatric Care
☐ Rheumatoid Fever
☐ Scarlet Fever
☐ Stroke
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcers
☐ Other
_____
_____
_____

Family History: Please indicate if any family members have had any of the following and if so, who:

☐ Diabetes _____
☐ Hypertension _____
☐ Stroke _____
☐ Alcohol Problems _____
☐ Mental/ Emotional Problems _____
☐ Heart Disease _____
☐ Hepatitis /Liver Disease _____
☐ Cancer _____
☐ Congenital Problems _____
☐ Other _____

Please describe any concerns and your objectives in seeking a L.I.F.E. Biofeedback Wellness Session:

_____
_____
_____
_____
_____

I understand that the attending Biofeedback Technician is not an allopathic doctor (M.D.) and does not portray herself/himself to be, but is providing biofeedback and wellness services. I understand that the services provided identify energetic imbalances. Procedures utilized include stress reduction protocols and biofeedback wellness consultation. I fully understand that the attending Biofeedback Technician does not offer allopathic drugs, surgery, chemical stimulants or any other conventional treatments. In addition, she/he does not diagnose, treat, or otherwise prescribe for my disease, conditions or illness, or perform any act that would constitute the practice of medicine for which a license is required. I have solicited the attending Biofeedback Technician's services in good faith, exercising my free will and following 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 Biofeedback Technician to do biofeedback testing, wellness consultation and other stress reduction protocols. The clinic has a 24-hour cancellation policy. Late cancellations or no-shows will incur a charge of $35.00.Please arrive 10 minutes prior to your appointment time. Late arrivals may be rescheduled and will incur a charge of $35.00. Payment is due at the time services are rendered. By signing below, I acknowledge that I have read and understand all parts of this waiver and that I have 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 any subsequent visit, solely on my own behalf.

Signature _____ Date _____