Information provided herein by you, the client, is confidential to the QEST practitioner working with you:

CLIENT INTAKE FORM

TODAY'S DATE_____

NAME	CELL PHONE
ADDRESS	STATUS: married ☐ widowed ☐ single ☐ divorced ☐
CITY STATE ZIP	SPOUSE / PARTNER'S NAME
DATE of BIRTH AGE:	REFERRED BY:
E-MAIL ADDRESS	IF CHILD, PARENT'S NAME
	OCCUPATION

Please use page four or back of space 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◯ N◯** Yes, it was ___lb___oz

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

3. Have you ever experienced "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 the approximate dates(s) or age(s).

5. Surgeries? **Y◯ N◯**

6. Have you ever experienced chiropractic manipulation? **Y◯ N◯** It was / is for: Neck☐ Upper back☐ 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◯** Please list.

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

9. Describe your diet. (Check the one(s) that 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 / fr 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
☐mumps
☐chicken pox
☐scarlet fever
☐bronchitis
☐pneumonia
☐rheumatic fever
☐asthma
☐hepatitis
☐HIV or AIDS
☐herpes
☐heart attack
☐pacemaker
☐cancer
☐chemo
☐radiation
☐vaccination
☐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 if:**
"A"=Always "F"=Frequent "S"=Sometimes

__migraines __headaches __stiff neck __difficulty turning head __upper back pain __lower back pain __sciatica (pain down leg) __hip pain R◯ L◯ __knee pain R◯ L◯ __ankle pain R◯ L◯ __foot pain R◯ L◯ __heel pain R◯ L◯ __elbow pain R◯ L◯ __wrist pain R◯ L◯ __hand pain R◯ L◯ __numbness / tingling fingers __shoulder pain R◯ L◯ __TMJ pain R◯ L◯ __dental problems / cavities __ringing in ears __pain in ears __dizziness __equilibrium problems __coordination problems __diminished sense of taste __diminished sense of smell __periodontitis __chest pain __pain in / behind sternum __pain in area of ribs __difficulty taking a deep breath __tickling in throat __difficulty swallowing __heartburn __discomfort after eating __stomach feels too full to eat __often don't feel like eating __intestinal gas __abdominal distention __intestinal pain __diarrhea __constipation __alternating diarrhea & constipation __rectal pain, fissures, bleeding __painful abdomen __hemorrhoids __gallstones	__fatigue __feeling of impending doom __depression __hyperactivity __attention deficit disorder __learning difficulties __trouble focusing / thinking __"fuzzy" headedness __trouble sleeping __tachycardia / rapid heartbeat __high blood pressure __very low blood pressure __anemia __chronic fatigue __diabetes known / suspected __high glycerides __high cholesterol-LDL __craving of sugar __low blood sugar __more tired after eating __known arthritis __painful joints __osteopenia __osteoporosis __chronic muscle pain __kidney stones __bladder infection __frequency of urination __wake up at night to urinate __difficulty urinating __burning pain with urination __impotence __frequent colds / flu __diminished immune response __cough, unproductive __cough, productive (phlegm) __swollen glands __sore throat __frequent hoarseness __frequent bloody nose __bruise easily __many moles / warts __acne or skin breakout __psoriasis __bruise easily __blood clots __cysts __tumors	__eye pain / dryness __known eye problems: _____ __TGIF __seizures __menopause __PMS __painful, abnormal periods __infrequent periods __drink diet soda __irregular periods __tired of questionnaires! __have had Botox injections __parasites known / suspected __accident-prone __prior reactions to energy work- please describe here: _____ __other:

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? (Looking for possible injuries here that you might not have thought about.)

18. Are you ambidextrous? Y◯ N◯ 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?
What are you most concerned about right now?
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 my past and current conditions. (or my child's)

Signature_____ ***date***_____