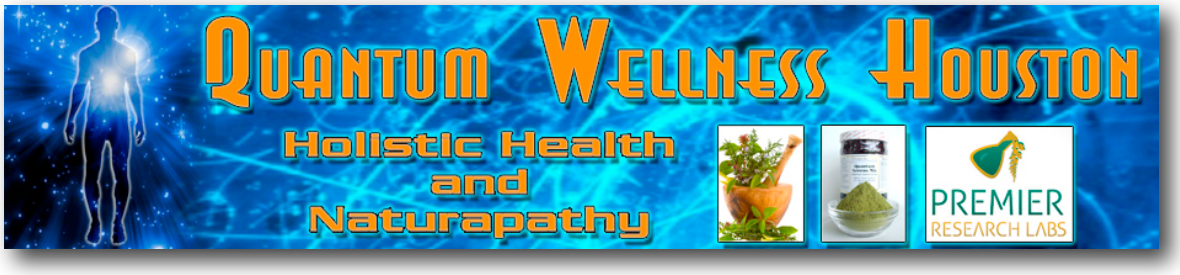

Patient Intake Form

Name _____

Address _____

City _____ State_____ Zip_____

Home phone _____ Work phone _____ Cell_____

Email Address_____

Birth date _____ Place of birth_____

Age____ Height_____ Weight_____

Marital status _____Gender: M F

Occupation_____

Referred by_____

Patient Waiver

I, _____ an individual seeking holistic health services, waive any right to bring suit against Renald Stettler and/or Quantum Wellness, LLC and its affiliates with respect to any holistic health services which I receive.

Dated and made effective this the _____ day of _____, 20__

Client Signature

_____

Please read carefully

Quantum Wellness services include Naturopathy, Holistic Health Counseling, Nutritional Counseling and Quantum Reflex Analysis. We also may recommend herbs or homeopathy. All recommendations are subject to discussion. Quantum Wellness is not intended to take the place of your medical physician. It is important that the information on this intake form be complete and truthful. It is very important to list ALL current medications, supplements, herbs, vitamins, minerals, and any other form of remedies being used at this time.

I understand that the attending practitioners are not allopathic doctors (MDís) and do not portray themselves to be, but are providing biofeedback and holistic services. I understand that the services provided identify energetic imbalances. Procedures utilized include stress reduction protocols, nutritional wellness consultation and biofeedback. I fully understand that the attending practitioners do not offer allopathic drugs (prescription drugs), surgery, chemical stimulants, or any other conventional treatments. In addition, we do not diagnose, treat or otherwise prescribe for a disease, conditions or illness, or perform any act that would constitute the practice of medicine for which a license is required. Any advice or recommendations should not be construed as replacement of allopathic doctor's diagnoses or prescription drugs.

I have solicited the attending practitioners 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 have read and understand all parts of this waiver, that I had the opportunity to ask any questions with regard to the described procedures, and that I hereby affirm: I am not here for medical diagnostic or treatment procedures and I am here on this and any subsequent visit solely on my own behalf. No medical claims are made as to the effect and outcome of alternative treatments or energy techniques.

Appointments at Quantum Wellness should be viewed as a complement to, rather than a replacement for, traditional medical approaches.

I have read and completed this form in its entirety. This is my consent for one or more services listed above.

Signed:_____ Date_____

Are you currently:

____Pregnant If yes, approximate date of conception
____Nursing
____Wearing a Pacemaker

Please check if you have or have had any of the following: if yes, list age to the right of each item

_ AIDS/HIV
_ Alcoholism
_ Allergy shots
_ Anemia
_ Anorexia
_ Appendicitis
_ Arthritis
_ Asthma
_ Bleeding Disorder
_ Breast Lumps
_ Bronchitis
_ Bulimia
_ Cancer, Type_____
_ Cataracts
_ Chemical dependency
_ Chicken pox
_ Depression
_ Emphysema
_ Epilepsy
_ Fractures
_ Glaucoma
_ Goiter
_ Gout
_ Heart disease
_ Hepatitis
_ Hernia
_ Herniated Disc
_ Herpes
_ High Cholesterol
_ Kidney disease
_ Liver disease
_ Measles
_ Migraine headaches
_ Miscarriage
_ Mononucleosis
_ Osteoporosis
_ Pacemaker
_ Parkinson's Disease
_ Pinched nerve
_ Pneumonia
_ Polio
_ Prostate problems
_ Psychiatric care
_ Rheumatoid Arthritis
_ Rheumatoid Fever
_ Scarlet Fever
_ Stroke
_ Thyroid Problems
_ Tonsillitis
_ Tuberculosis
_ Tumor growths,where_____
_ Ulcers
_ Whiplash

Other:

Contagious diseases :

(Check if you have ever had one of the following):

_ HIV _ AIDS _ Hepatitis _ Venereal Disease _ Herpes _ Chlamydia _ Gonorrhea _ Syphillis _ Mono _ Epstein Barr
Other _____

Habits:

_ Cigarettes
_ Coffee
_ Black Tea
_ Marijuana
_ Soft Drinks
_ Alcohol
_ Sugar
_ Occupational Hazards
_Salt
_ Recreational Drugs
_ Stress
_ Other _____

Artificial Sweeteners - Circle one or all:

Aspartame (Equal) Saccharin (Sweet N Low) Splenda (sucralose)

Emotional:

I would generally describe myself as:

_ Happy	_ Easy going	_ Irritable
_ Indecisive	_ Angry	_ Cry easily
_In a hurry	_ Depressed	_ Stressed out
_ Restless	_ Emotional Other_____	

Diet (Typical Foods): Check all that you eat on a regular basis

_ Beef	_ Eggs	_ Cheese
_ Grains	_ Tofu	_ Pork
_ Bread	_ Margarine	_ Fried Foods
_ Yogurt	_ Poultry	_ Milk
_ Ice Cream	_ Sweets	_ Health Foods
_ Fish	_ Butter	_ Vegetables
_ Salads	_ Hot Spicy Food	_ Organic
_ Fast Food	_ Packaged Food	_ Microwaved Food

Some questions may be repetitive, but are grouped together in certain ways that are beneficial during a session.

MAJOR COMPLAINTS - Describe your top concerns and your objectives in seeking services here (Reason for Visit):

_____
_____
_____

Have you ever had this condition or similar condition before? Yes No
Have you ever received treatment for this condition? Yes No
If yes, when? By whom?

_____
_____
_____

What was the diagnosis? What were the results of the treatment?

_____
_____
_____

Recently the condition has: _Improved _Worsened _Stayed about the same

What makes it better? _____

What makes it worse? _____

Describe what caused it or how it started: _____
_____

Please list any and all other current ongoing symptoms, diagnosis and concerns:
_____
_____
_____

Overall, how would you rate your current health? _ Excellent _ Very Good _ Good _ Fair _ Poor _ Very Poor

FAMILY MEDICAL HISTORY (Mother, father, or grandparents):

_ Cancer	_ Diabetes	_ High or Low Blood Pressure
_ Heart disease	_ Tuberculosis	_ Allergies
_ Kidney Disease	_ Liver Disease	_ Epilepsy
_ Asthma	_ Ulcers	_ Sinus problems
_ Eye disorders	_ Arthritis	_ Alcoholism
_ Spinal problems	_ Mental disorders	_ Drug addiction

Other:

_____

PERSONAL MEDICAL HISTORY:

Major Surgeries - Illnesses - Diseases - Accidents, Start with most recent and work backwards, use back of page if you need additional space

Date Description

_____

_____

_____

_____

Blood Type (If known, please find out before your appointment if possible), Circle one: A O B AB

Number of Organs removed (including tonsils, appendix and adenoids, please List them)
_____

Number of synthetic drugs used currently (includes prescriptions and over the counter drugs) please List name of medication, what you are taking it for, and how often:
_____

_____

_____

_____

_____

- Number of cigarettes per day (if applicable)_____
- Have you ever used steroids drugs _____
- Number of steroid type drugs used in the past year (includes cortisteroid drugs and creams)
- Number of amalgam (silver) fillings currently in your mouth _____
- Number of all known allergies (drugs, food, chemicals, animals, seasonal, etc)__
- Number of unresolved emotional factors (anger, depression, anxiety, resentment, etc.)
  _____
- Average amount of fat in daily diet _____%(Includes meat fat, oils, butter, etc.
- Average amount of protein in daily diet ____% (Includes meat, chicken, soy, whey, dairy, nuts)
- Average amount of carbohydrates in daily diet ___% (Includes starches, bread, pasta, sodas, sugar, deserts, vegetables and fruits)
- Personal stress on a scale from 1 to 10, 10 being high and 1 being low _____
- Number of sugar type servings/products in a day, including sodas (actual refined sugar products)
- Number of exercise sessions in a week, 30 minutes or more _____ Type of exercise
  _____
- Number of alcoholic drinks in a day, on average____
- Number of caffeine products per day (coffee, tea, soda)____
- Number of major infections in the past (involving hospitalizations or Rx for a month or more)_____
- Number of glasses of water per day_____
- Number of times antibiotics used in the past 2 years_____
- If you are overweight, how many pounds?____

Woman Only this page

Menstrual Cycle:
Age started _____ Days of flow _____ Age stopped____

How many days from the beginning of your period to the start of your next period? One complete cycle_____
Check all that apply:

Irregular cycle painful Heavy flow _	Scanty flow _	Dark Color flow _
Light color flow _	Clotting _	Water Retention _
Abdominal _	Bloating _	Painful or tender breasts _
Breast Lumps _	Emotional changes _	Spotting between periods _
Lump in throat feeling _	Painful cramps _	Backache _
Tightness in chest _	Hormonal problems _	
Sigh a lot _	Constipation and/or diarrhea _	

Other _____

Vaginal discharges: __Yellow __ Thick __ Bad odor __ White __ Clear __ Other_____
Describe week before cycle and during cycle:

Menopause problems (describe in detail):

Pregnancies:
Total number ____ Number of miscarriages ____ Number of children ____ Number of abortions ____

Pregnancy or childbirth complications (please describe):

Gynecological history and operations
_ Ovaries _____
_ Uterus _____
_ Fallopian tubes_____
_ Vagina_____
_ Breasts_____
_ Other_____

Do you currently use birth control? Yes No
If yes, what method are you currently using?

Have you used birth control in the past? Yes__ No__ For how Long? _____ When did you stop?_____
If yes, what method(s)?_____

…Continued from page 7

Headaches/dizziness: When you have headaches, where does It hurt specifically (above eyes, behind ears etc.)
_____
_ Headaches Vertigo _ Bend down and stand up and get dizzy
_ Dizziness _ Motion sickness _ Poor balance
_ Faint easily _ Migraines _ Poor memory
_ Blackout _ See spots _ Nausea _ Other _____

Skin:
_ Dry _ Hives _ Itching _ Oily _ Acne _ Bruise easily _ Eczema _ Normal
_ Rashes _ Cuts heal slowly _ Balding where? _ Other_____

Hair:
_ Dry _ Oily _ Dandruff Hair Loss _ Early grey Normal _ Other _____

Nails:
_ Soft _ Spots _ Grow slowly _ Ridges and lines _ Purple _ Normal
_ Break easily _ Pale _ Grow fast _ Other _____

Eyes:
_ Wear glasses or contacts _ Eyelids swollen _ Red _ Dry Itch _Poor night vision _ Twitch _ Pain _ Sensitive to light _ Color blindness _ Tear easily _ Normal _ Feels like sand under eyelid _
Other_____

Ears:
_ Poor hearing _ Ringing (high pitch) _ Ringing (low pitch) _ Discharges _ Ear aches _ Normal _ ears smell _
Other_____

Nose:
_ Stuffy nose _ Hay ever _ Sneeze a lot _ Environmental sensitivity Mucous _ Bleeding _ Loss of smell _ Blow nose a lot _ Sinusitis _ Normal Other _____

Mouth and throat:
_ Dry _ Gum problems _ Frequent colds _ Difficulty swallowing _ TMJ _ Feel lump in throat _Thyroid problems _ Grind teeth _ Normal _ Recurrent fever blisters Other _____

Respiratory:
_ Shortness of breath _ Difficulty inhaling _Sigh a lot _ Chest pain _Difficulty exhaling _Dry cough _ Asthma _ Difficulty Breathing _ Cough with phlegm _Bronchitis _ Emphysema _ Cough with blood _ Tightness in chest _ Wheezing Other
_____

Cardiovascular:
_ Diagnosed heart problems _ Palpitations low blood pressure _ Bleed easily High blood pressure _ High cholesterol _ Murmur _ Varicose veins _Ankle swelling _ Chest pain _ Bruise easily _ Hand swelling _ Irregular heart beat _ Numbness in extremities _ Normal _Other _____

Pain: Severity of pain _ none _ mild _ moderate _ severe

where and why
_ Low back _ Shoulder _ Muscle weakness _ Sciatica _ Hands or wrists _ Muscle cramps _ Upper back _ Hips _ Muscle twitching or spasm _ Mid back _ Knees
_ Neck _ Foot or ankle _ Nerve _ Spine _ Arthritis _ Flank area Other_____ _____
Aches/stiffness in bones or joints? When? (A.M., P.M., upon waking, after exercise)

Appetite:
Are you hungry in the morning? _ Yes _ No
Up and down _ Poor _ Good _ Hungry a lot _ Loss of taste
Do you eat three meals per day? _ Yes _ No Do you eat at regular hours? Yes No
Cravings_____

Describe eating habits in detail:
_____

_____

_____

_____

_____

Weight:
_ Normal _ Underweight _ Overweight _ Recent gain _ Recent loss
If recent gain or loss, how much? _____ Since what date? _____
If overweight, how many pounds do you want to lose? _____ Desired weight_____
Energy:
_ Up and down _ Low _ Normal Excess _ Low after eating
_ Tired in the afternoon Other _____
Fatigued? When? How often and for how Long?_____

Body temperature:
_ Warm natured _ Flushed face _ Feel warmer late afternoon and night _ Sweat Easily _ Night Sweats _ Cold natured _ Warm Palms _ Alternate chills and fever

_ hands feet and/or groin sweat abnormally _ Do not Sweat

Digestion:
_ Indigestion _ Bloating _ Heartburn _ Nausea Vomiting _ Full feeling or distention _Belch or burp _Abdominal pain or cramps _ Gas _ Difficulty digesting fatty or oily foods _ Bitter taste in mouth _ Gallstones
_ Normal _ Acid Reflux _ Take antacids frequently _ Other_____

Bowels:
_ Loose stool _ Diarrhea _ Hemorrhoids _ Constipation _ Colon problems _ Pain or cramps _ Use laxatives _ Normal _ Other
Average number of bowel movements per day_____

Urination:
Color (circle one): _ clear _ light yellow _ yellow bright _ yellow dark other_____
_ Burning _ Bladder infections _ Urgency _ during sleep _ Incontinence
_ Kidney stones or infections _ Normal _ Other _____

Thirst:
_ Less than normal _ Excessive _ Normal _ Thirsty but do not drink
# of drinks (glasses of water) per day_____
I prefer my drinks (circle one): cold warm/hot room temperature
Other _____

Sleep:

Falling asleep:	Easy	Average	Difficult
Staying asleep:	Easy	Average	Difficult
Waking up:	Easy	Average	Difficult

Sleep quality (check all that apply):
_ Restless _ Lots of dreams _ Easily awakened _ Nightmares _ Difficulty falling back to sleep
If you wake at the same time each night, what time? _____
How many times do you wake up during the night? _____ Other_____