Blue Sky Healing Biofeedback Intake Form

Name: ____Date: _____________________

Address: ____

Phone:_________________________Email: ____________________________________

☐ Please add me to your email list for information updates.

Birthdate:____________________ Place of Birth: _________________________

☐Female ☐Male

☐Married ☐Divorced ☐Widowed ☐Single ☐Separated

Occupation: _______________________ Employer: ________________________

Name of Spouse:______________________________DOB___________________

Person to contact in case of an emergency:______________________________

Phone: _________________________________ ☐ Home ☐Cell ☐Work

SOC INDEX:

Number of organs removed		Personal stress (1-10) 10 is High	
Number of synthetic drugs used currently		Number of sugar type products in a day (1-10)	
Number of times you smoke in a day		Number of exercise sessions in a week	
Number of steroid type drugs used in the past year		Number of alcoholic drinks in a day (avg.)	
Number of amalgam (silver) fillings in your mouth		Number of caffeine products per day (coffee, tea, soda)	
Number of street drugs used each month		Number of toxic exposures (radiation, chemicals, insecticides, etc.)	
Number of known allergies		Number of major injuries in the past	
Number of unresolved emotional factors (anger, depression, anxiety, etc)		Number of major infections in the past	
I am responsible for my body 1-10		Number of 8 oz. glasses of water per day	
Amount of fat in diet 1-10%		Number of pounds overweight	

Please check if you have or have had any of the following:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Breast lumps
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cataracts
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated disc
- ☐ Herpes
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ 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 growth
- ☐ Ulcers
- ☐ Other:

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

- ☐ Diabetes_______________________________
- ☐ Hypertension__________________________
- ☐ Stroke ________________________________
- ☐ Alcohol problems______________________
- ☐ Mental/emotional problems____________
- ☐ Heart Disease_________________________
- ☐ Hepatitis/liver disease__________________
- ☐ Cancer_________________________________
- ☐ Congenital problems___________________
- ☐ Other__________________________________

Describe any concerns and your objectives in seeking wellness services here:

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I understand that the attending practitioner is not an allopathic doctor (MD) and does not portray them self to be, but is providing biofeedback and wellness services. I understand that the services provided identify energetic imbalances. Procedures utilized include stress reduction, pain management, muscle re-education and brainwave balancing. I fully understand the practitioner does not offer allopathic drugs, surgery, chemical stimulants, or any other conventional treatments. There will not be diagnosis, treatment or prescription for my disease/conditions/illnesses or any act that would constitute the practice of medicine for which a license is required. I have solicited the practitioner'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 to be the most beneficial to my health. I am fully aware and release the practitioner to do to biofeedback training and other stress reduction protocols. By signing below, I acknowledge that I have read and understand all parts of this waiver, that 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.

Signature: ____Date:_____________

Blue Sky Healing 216-262-8886