



Ahhz Confidential Client Form

Name: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Place of Birth: _____

Time of Birth: _____

Home Phone #: _____ Work Phone #: _____

Female Male Married Divorced Widowed Single Separated

Occupation _____

Person to contact in case of an emergency: _____

Home Phone # _____ Work Phone # _____

Pregnant : yes ____ no ____ Do you have a Pacemaker? Yes ____ no ____

SOC INDEX:

Number of organs removed		Personal stress (1-10)	
Number of synthetic drugs used currently		No. of sugar type products in a day (1-10)	
Number of times you smoke in a day		Number of exercise sessions in a week (at least 20 min. not including work activities)	
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 all 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 glasses of water per day	
% of fat in diet (Normal diet is 40%)		How many pounds overweight	

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

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> PINCHED NERVE |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> PNEUMONIA |
| <input type="checkbox"/> ALLERGY SHOTS | <input type="checkbox"/> GOITER | <input type="checkbox"/> POLIO |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> GOUT | <input type="checkbox"/> PROSTATE PROBLEMS |
| <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> APPENDICITIS | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> RHEUMATOID ARTHRITIS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HERNIA | <input type="checkbox"/> RHEUMATOID FEVER |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HERNIATED DISC | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> HERPES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> BREAST LUMPS | <input type="checkbox"/> HIGH CHLOSTEROL | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> BULIMA | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> TONSILITIS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> MEASLES | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CATARACTS | <input type="checkbox"/> MIGRAINE HEADACHES | <input type="checkbox"/> TUMOR GROWTHS |
| <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> MISCARRIAGE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> COPD | <input type="checkbox"/> MULTIPLE SCLEROSIS | _____ |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> OSTEOPEROSIS | _____ |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> PACEMAKER | _____ |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> PARKINSON'S DISEASE | _____ |

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

- | | |
|--|--|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Alcohol Problems _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Congenital Problems _____ |
| <input type="checkbox"/> Hepatitis/Liver Disease _____ | <input type="checkbox"/> Mental/Emotional Problems _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Other _____ |

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

I understand that the attending practitioners are not allopathic doctors (MDs) and do not portray themselves to be but are providing biofeedback and wellness 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, surgery, chemical stimulants, or any other conventional treatments. In addition, we do 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 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 I 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.

Signature of Client

Date