***Client Intake Form***

***CELLULAR FULL BODY SCAN ANALYSIS***

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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E-MAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTHDATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ORGANS REMOVED/SURGERIES: (If any)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE LIST ANY MEDICAL CONDITIONS/ILLNESESS YOU CURRENTLY HAVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PLEASE LIST DIETARY SUPPLEMENTS or MEDICATIONS YOU ARE CURRENTLY TAKING: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PLEASE LIST ANY AREAS OF CONCERN:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***MIND BODY TRANSFORMATION SANCTUARY INC.***

***Wellness, & Bio-Feedback Consultation***

***Waiver & Consent Form***

1. I fully understand the difference between the practice of allopathic (conventional) medicine (MD), nutritional wellness consulting, and Bio-Feedback technician.
2. I fully understand that the services provided by the attending technician are not allopathic and does not portray his/her self to be one, but are strictly non-invasive.
3. Any reference to patients within the frequency balancing is solely due to the technical terminology within the Full BodyScan Analysis program and in no way implies that the client is a medical patient.
4. I fully understand that the attending technician performs his/her services within the parameters of a natural health care and wellness system using Bio-Feedback and stress reduction.
5. I fully understand that the attending technician does not offer allopathic drugs, surgery, chemical stimulants, radiation, or any other conventional treatments. In addition, he/she does not diagnose illness or treat disease or claim to cure. It is my understanding that this system measures my wellness state and stress parameters to enhance the communication within the areas of the body/mind complex that are in as state of imbalance.
6. I have solicited the attending Bio-Feedback technician’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 is most beneficial to my health.
7. I also exercise my free will in asking this business and technician for their opinion on items and situations which may expedite my good health; it is my choice should I accept to utilize or apply any of those ideas or suggestions at any time.
8. If I desire any services not provided by the attending Bio-Feedback technician, which is my prerogative, I fully understand that I should seek them elsewhere.
9. I presently seek counsel, advise, opinions, or points of view and/or programs within the scope of the attending technician’s wellness and stress reduction practice. I am fully aware and release the Bio-feedback technician to do Bio-feedback stress interpretations and frequency balancing.

11. I understand that payment is expected at the time of service.

1. I understand that I must call and cancel an appointment at least 24 hours prior to my scheduled appointment time. If I do not show up for a scheduled appointment I will be charged 100% of the cost of the session.
2. 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 any questions with regard to all such procedures.
3. I understand that is my responsibility to advise the technician when observing or participating in a session, when employed by the FDA or any other governmental agency.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_