**EPR BIOFEEDBACK CLIENT GENERAL INTAKE FORM**

Name (please print):

_____

D.O.B. _____

Phone: (Cellular)_____

Address: _____

City, State, Zip_____

Place of Birth (include city, please)_____

Email Address_____

Time of Birth (optional if you know it)_____

Medications and dosages:_____

Are you currently under the care of a primary physician? ___Yes____No

How did you hear about us? Please be specific. If through referral, who may we thank?

_____

Have you ever had an EPR Biofeedback Session before? ___Yes____No

If yes, when was your last session? _____

Please specify the number of previous sessions. _____

Are you sensitive to touch?___Yes___No

Do you have a particular area of concern? ___Yes___No_____Unsure

If yes, please tell us the reason for your session today (be as specific as possible):

Specific Issues:

Physical:_____

_____

Emotional:_____

_____

Mental: _____

_____

Spiritual:_____
_____

Are you under stress? On a scale of 1-2-3-4-5-6-7-8-9-10, where 1 is minimum stress and 10 feeling you are under extreme stress, please circle the number you most identify with.

Please explain: _____

Do you have a pacemaker? ____YES____NO

Have you been diagnosed with Epilepsy or have seizures? ___YES___NO

Are you Pregnant? ___YES___N/A

Is your child under the age of three years of age? ___YES___N0

Are you taking prescription drugs? YES___N0___ If yes, please specify as best you can.

_____

_____

Do you take multi-vitamins on a regular basis? YES___NO___

Do you know if you absorb nutrients well? YES___NO___

Do you suffer from gas, bloating or indigestion? ___YES___NO___Unsure

Do you have any known food allergies or intolerances? ___YES___NO If yes, please specify below.

_____

Do you suffer from a gastrointestinal disorder such as inflammatory bowel disorder or leaky gut syndrome? ___YES___N0

Do you eat a diet that is high in sugars and processed food?___YES___N0

Are you prone to infections?___YES___N0

Do you use antacids on a regular basis?___YES___N0

Do you smoke?___YES___N0

Do you drink? YES___NO___ If yes, how many times per week do you drink? _____

Are you exposed to heavy metals?___YES___N0

How many glasses of water do you drink approximately every single day? Please circle the number that reflects best your behavior.

1 - 2- 3- 4- 5- 6- 7- 8 more than 8

Are you overweight? YES___NO___

If so, about how many pounds overweight?

5- 10- 15- 20- 25- 30- 35- 4O- 50 or more

Have you had any injuries in the past? YES___NO___ if yes, please explain what area in the body was affected the most. _____

PLEASE READ CAREFULLY AND SIGN BELOW

I understand that the intended purpose of biofeedback training is for relaxation and muscle re-education so I may learn to: 1) reduce my stress, 2) manage my pain, and/or 3) improve the equality of my health and my life. I understand biofeedback training is considered safe.

I further understand that biofeedback is not a substitute for effective standard medical, chiropractic or psychotherapy treatment. Beatriz Cymberknopf has advised me to continue ongoing medical treatment and therapies until otherwise advised by my medical physician or medical practitioner. I further understand it is my responsibility to ask my medical doctor for permission to undergo biofeedback training if I wear a peacemaker or have any medical condition that may be exacerbated by relaxation.

I understand it is my responsibility to monitor the effects of biofeedback training and to continue the training for as long as it is beneficial to me. I further understand that research suggests that while most people gain considerable benefits from quantum biofeedback training, I understand there is no guarantee that it will.

Signed _____ Date _____

Print Name _____