

Love Health & Healing Center

Client Profile

Name: _____ Age: _____ Birthdate: _____
 Birth Location (City: _____ (State) _____ Sex: M F
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Marital Status: Married Divorced Single Widowed Separated
 Occupation: _____ Full Time Part time Retired Student
 Employer's Name and Address: _____
 Emergency Contact: _____ Relationship: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone: _____ Referred by: _____

A NOTE TO OUR CLIENTS: Biofeedback is only possible when the Specialist has a complete picture of the client – physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

In your opinion, what are you most important health problems?

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

What health problems do you want to talk about today List them in the order of importance.

- | | |
|----------|----------|
| 1) _____ | 3) _____ |
| 2) _____ | 4) _____ |

Your Health History – Please check the relevant areas and give some details below:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Miscarriage(s) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Colitis | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes Genitalis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Fractures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disorders | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Psychological Disorders | <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tumor Growths | |
| <input type="checkbox"/> Rheumatoid Fever | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Ulcers | |

Other: _____

Family History – Please check yes, no, or don't know (?) for blood relatives

| YES | NO | ? | | YES | NO | ? | | YES | NO | ? | |
|-----|----|---|---------------------|-----|----|---|---------------------------|-----|----|---|---------------------|
| | | | Alcoholism | | | | Gout | | | | Seizure or Epilepsy |
| | | | Anemia | | | | Hay Fever | | | | Sickle Cell Anemia |
| | | | Asthma | | | | Heart Disease | | | | Skin Disorders |
| | | | Hemophilia | | | | High Blood Pressure | | | | Stroke |
| | | | Cancer | | | | Hypoglycemia | | | | Thyroid Disorders |
| | | | Congenital Problems | | | | Hypertension | | | | Tuberculosis |
| | | | Diabetes | | | | Mental/Emotional Problems | | | | Venereal Disease |
| | | | Glaucoma | | | | Auto Immune Disorder | | | | |

HOSPITALIZATIONS: (Dates and type of illnesses/operations)

KNOWN ALLERGIES: (To Medications, Foods, Pollens, Etc.)

PRESCRIPTION MEDICATIONS:

HEALTH HABITS: (Primary interests, hobbies, or activities)

Drugs & Alcohol:

Do you drink alcohol? No Yes, how often and what kind? _____

Do you use recreational drugs? No Yes, how often and what kind? _____

Do you use, or have you ever used tobacco? No Yes

If yes, please answer the following questions:

What kind? Cigar Cigarettes Chewing Tobacco Pipe

How long ago? Current User Quit in last 6 months Quit 1-3 years ago Quite more than 3 years ago

How much per day (in packs, etc.)? _____ and for how many years? _____

Diet & Lifestyle:

What kind of foods, if any, do you usually exclude from your diet?

Everyday, I consume: (Please circle how many servings per day)

- Fruits
- Vegetables
- Green Foods
- Fried Foods
- Nuts (2 oz or 1/4 cup is a serving)
- Glasses of Water (8 oz.)
- Cups of Coffee (6 oz.)

How many: (Please circle number that applies)

- Bowel Movements per day
- Hours of Sleep per night
- Number of Meals per day
- Occurances of Back Pain per day

I usually eat this for breakfast: _____

I usually eat this for lunch: _____

I usually eat this for dinner: _____

I usually eat this for protein each day: _____

I usually eat these nuts daily between meals: _____

I usually use these oils when I cook: Coconut Olive Canola Vegetable Shortening

I usually eat the following: Butter Margerine

I usually use the these sweeteners: White Sugar Brown Sugar Splenda Sweet N'Low
 Honey Stevia Xylitol

I cook with the following cookware: Teflon Aluminum Stainless Steel Other _____

I use the microwave for the following foods: _____

How many servings of sugar per day (candy, soda, white bread, white pasta, white sugar, white rice, non-whole grain cereals, donuts, etc.) ? _____

List 4 high fiber foods you eat daily: _____

How much time do you spend on a cell phone monthly: _____

Do you live close to any major electrical towers? Yes No

How many days per week do you normally get at least 30 minutes of sunshine? 1-7 _____

When I want a snack, I reach for... _____

How many days per week do you normally get at least 20 minutes of aerobic exercise? 1-7 _____

How many days per week do you normally do strength training? 1-7 _____

Other:

In the past four weeks, I have experienced a persistent cough, chest tightness or heaviness, wheezing, extreme fatigue and/or acute shortness of breath (Please circle specific symptom you are experiencing).

- Never 2 times a week Daily Continually

In the past four weeks, I have been awakened at night by a cough, chest tightness or heaviness, wheezing, and/or shortness of breath (Please circle specific symptom you are experiencing).

- Never 2 times a week Daily Continually

When I wake up in the night, it's at: 12 am 1 am 2 am 3 am 4 am Other _____

Taking care of me:

I do the following things to help me manage my stress:

I understand that Certified Biofeedback Specialists are providing biofeedback and wellness services. I agree that I am receiving suggestions to improve my health. It is my choice and responsibility to improve my health/stress levels.

Signature

Date



Love Health & Healing Center Biofeedback Consultation Waiver

1. I fully understand that the attending specialists are not allopathic doctors (MD's), but are nutritional wellness consultants and are Biofeedback Specialists.
2. I fully understand the difference between the practice of allopathic medicine, nutritional wellness consulting, and Biofeedback.
3. I fully understand that the services provided by the attending specialists are not allopathic, but are nutritional, behavioral, or biofeedback in nature.
4. I fully understand that the attending specialists perform their services within the parameters of a natural health care and wellness system using Biofeedback and Stress Reduction.
5. I fully understand that the attending specialists do not offer allopathic drugs, surgery, or chemical stimulants or radiation therapy. I understand that illness is not being diagnosed not treated and that my wellness and stress are being measured.
6. I have solicited the attending Biofeedback Specialists' 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 beneficial to my health.
7. If I desire any services not provided by the attending Biofeedback Specialists, which is my prerogative, I fully understand that I could seek them elsewhere.
8. I presently seek counsel, advice, opinions, Biofeedback, or points of view and/or programs within the scope of the attending specialists' wellness and stress reduction practice.
9. I fully understand that the services provided by the attending specialists are not generally accepted and/or recommended by allopathic doctors or other conventional health professionals.
10. I hereby release the Biofeedback Specialists to do Biofeedback tests and treatments.

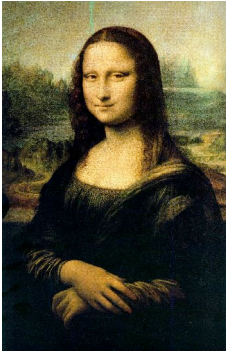
Client Signature _____ Date: _____

Address: _____

Phone: _____ Email: _____

Date of Birth and Time: _____ Birthplace/Location: _____

3150 N. Arizona Ave., Suite 117 • Chandler, Arizona 85225
www.lovehealingcenter.com • (602) 377-7777 • (480) 235-6369



Love Health & Healing Center

SOC Questionnaire Form

Please answer the questions below to the best of your ability...

Name: _____

Date and Time of Birth: _____

Birthplace: _____

Number of organs removed: _____

Number of synthetic/prescription drugs used currently: _____

Amount of times per day that you smoke: _____

Number of steroid drugs used in the past year: _____

Number of metal amalgam fillings: _____

Number of street drugs used monthly: _____

Number of known allergies: _____

Number of unresolved mental factors (like trauma, worry, issues with money): _____

On a scale of 1-10 (1 – not at all, 10 – very), how responsible are you for your body: _____

Amount of fat in your diet in percentage: _____

On a scale of 1-10 rate your personal stress: _____

Number of sugar type products per day (soda, candy, ice cream): _____

Number of exercise sessions per week: _____

Number of alcoholic drinks per day: _____

Number of caffeine products per day (coffee, tea, soda): _____

Number of major injuries in the past: _____

Number of major infections in the past: _____

Number of glasses of water per day: _____

How many pounds overweight do you believe you are: _____

Love Health & Healing Center

Biofeedback Client Services Contract

Welcome to Love Health & Healing Center. This document contains important information about my professional services and business practice. Please read carefully and ask any questions you have about our Center.

Biofeedback requires an active effort on your part, and in order to be successful you will need to be willing to make certain lifestyle, behavioral, and/or dietary changes. Biofeedback sessions take a comprehensive approach to wellness, focusing on the body, mind and spirit. Biofeedback sessions can be very effective in relieving stress. Your initial visit is an information gathering session that allows your specialist to better evaluate your stress related issues. If you have any questions or concerns, please let your specialist know at your initial visit so they may be addressed immediately.

Professional Fees

Fees for service are paid at each appointment unless other arrangements have been made prior to any appointment. I fully understand that a 24 hour cancellation notice is required for all scheduled visits and that I am responsible for a cancellation fee of \$80 if I fail to keep my scheduled appointment without at least 24 hours notice. Furthermore, I understand that fees are due at the time of service and that it is my individual responsibility to submit insurance forms and/or paperwork to receive insurance reimbursement for services received by Love Health & Healing Center.

Confidentiality

Information regarding your session will not be released without written permission except in the following circumstances, which are mandated by law:

If you threaten grave bodily harm to another person or yourself, I am required to inform the intended victim and appropriate law enforcement agency, family members or others who can provide protection. I am under legal obligation to warn and protect.

I must report actual or suspected abuse to children, the elderly, or disabled.

I must comply when a report is ordered by a Court of Law.

Please be aware that insurance health care plans may involve direct clinical management by the insurance company and may have some impact on confidentiality. Please refer to HIPPA notice of Privacy Practices for more information regarding how your personal health information is utilized.

Natural Substances

If I am given the opportunity to purchase anything, including energetic devices from Love Health & Healing Center, I understand that I am under no obligation to purchase anything.

Emergencies

I understand that if I have an urgent medical condition, I am to seek appropriate medical care. **I further understand that if there is a medical emergency or serious medical concern, I am to call 911 immediately.**

Consent to Treatment

I authorize Love Health & Healing Center to administer and perform such general procedures with the use of the EPFX/SCIO Biofeedback equipment. I understand that no guarantee or assurance has been made as to the results that may be obtained from such treatment. I understand that Love Health & Healing Center intends to provide top quality service. However, if I am unhappy with the services I received, I intend to immediately inform Love Health & Healing Center and/or staff so that my concerns/complaints can be addressed immediately. If I am pleased with my session, I have the option of referring my friends and family.

I have read this form and agree to all of its contents with my signature below.

Client Signature _____ Date: _____
(Signature of client or one parent or guardian if client is under 18 years of age)

3150 N. Arizona Ave., Suite 117 • Chandler, Arizona 85225
www.lovehealingcenter.com • (602) 377-7777 • (480) 235-6369

Privacy Notice - Please Sign

LOVE HEALTH & HEALING CENTER

I acknowledge that I have read and understand the Notice of Privacy Practice at Love Health & Healing Center.

Client Name (Printed)

Client Signature

Date

If client is a minor, signature of parent or guardian

Parent or Guardian Signature

Notice of Privacy Practice

To our clients: this notice describes how health information about you (as a client of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulation created as a result of the Health Information Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use and disclose of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety, or the person or organization able to prevent threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. The Federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workman's Compensation and similar programs.

Your rights regarding health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, you must submit your request in writing to Love Health & Healing Center, attention Privacy Officer. You must provide us with a reason that supports your request for amendment.
4. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our office.
5. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Love Health & Healing Center, attention: Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
6. Right to provide an authorization for other used and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If a disclosure of your protected health information was made for a reason other than treatment, payment, health care operation, you have the right to receive an accounting of the disclosure.

If you have any questions regarding this notice our health information privacy practices, please contact Love Health & Healing Center, Attention: Privacy Officer.