4550 Eubank Blvd. NE Suite 205
Albuquerque, NM 87111
505-797-0540

Name:		Date:
Address:		
City:	State:	Zip Code:

Phone:	Home	Work	Cell
Email Address:			
Birth place:	Birth time:	Sex:	Date of Birth:

Marital Status:	Single	Married	Separated	Divorced	Widowed
Occupation:			Employer:		
Physician:			Chiropractor:		

Current Medical Problems / Medications:
Past Medical Problems / Medications:

Prior Abnormal Lab Tests, X-Rays, EEG, etc.:
Prior Hospitalizations / Prior Abnormal Lab Tests, X-Rays, EEG, etc.:

Surgeries / Abdominal Surgeries:	Have you ever had trouble with scar tissue?

Allergies / Drug Intolerances:

Current Stresses (work, family, personal):

Insect extermination at work or home?:	
Do you feel better or worse away from home?:	

Please describe any concerns you have and your objectives in seeking wellness services here:

How did you hear about us?	

Albuquerque
Natural Health Center
Powerful, Positive Healing for Life

Personal History: Please check if you have had any of the following medical conditions:

- [ ] Aids/HIV
- [ ] Alcoholism
- [ ] Allergy Shots
- [ ] Anemia
- [ ] Anorexia
- [ ] Appendicitis
- [ ] Arthritis
- [ ] Asthma
- [ ] Bleeding Disorder
- [ ] Breast Lumps
- [ ] Bronchitis
- [ ] Bulimia
- [ ] Cancer
- [ ] Cataracts
- [ ] Chemical Dependency
- [ ] Chicken Pox
- [ ] Congenital Problems
- [ ] Depression
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Fractures
- [ ] Glaucoma
- [ ] Goiter
- [ ] Gout
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] Hernia
- [ ] Herniated Disc
- [ ] Herpes
- [ ] High Cholesterol
- [ ] Hypertension
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Measles
- [ ] Mental/Emotional Problems
- [ ] 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 Growths
- [ ] Ulcers
- [ ] Other ______________________________

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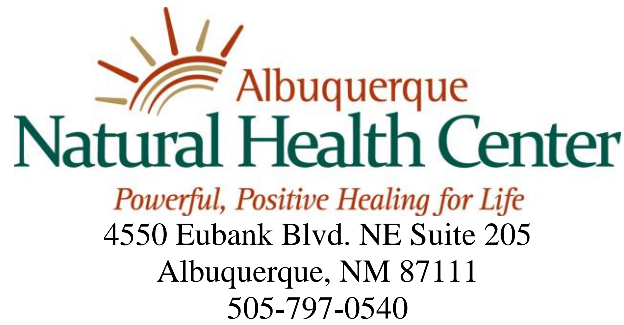
Family History: Please indicate if any family members have had any of the following medical conditions and if so, indicate who on the line below:

- [ ] Alcohol Problems
- [ ] Cancer
- [ ] Congenital Problems
- [ ] Diabetes
- [ ] Heart Disease
- [ ] Hepatitis/Liver Disease
- [ ] Hypertension
- [ ] Mental/Emotional Problems
- [ ] Stroke
- [ ] Other

SOC Index

Number of organs removed		Personal stress (1-10)	
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 drugs used in the past year		Number of alcoholic drinks in a day (average)	
Number of amalgam (silver) fillings in your mouth		Number of caffeine products per day (coffee, tea, soda, etc.)	
Number of street drugs used each month		Number of toxic exposures (radiation, chemicals, pesticides, 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 glasses of water per day	
Amount of fat in diet (1-10)		How many pounds overweight	



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I understand that the attending practitioner is not an allopathic doctor (MD) and does not portray herself to be but is 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 practitioner does not offer allopathic drugs, surgery, chemical stimulants, or any other conventional treatments. In addition, practioner does 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 practioner'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.

I am fully aware and release the practioner to do biofeedback testing, wellness consultation and other stress reduction protocols. The Team at Albuquerque Natural Health Center respects your privacy and will maintain your session results under strict confidentiality.

I release the Practitioner from any liability whatsoever regarding my session. I take full and total responsibility for my health and I realize that success depends upon commitment on improving the health.

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

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PAYMENT:
How are you paying? (Please check one) Credit Card:______ Check:_____
Please mail checks to the address above and call the office for credit card processing.

CANCELLATION POLICY:
As part of our continued effort to provide you with the very best of service and accommodate all appointment requests, we have implemented a cancellation policy.

There is a 50% charge for cancellations made less than 24 hours in advance and a 100% charge for no-shows.

______________________________ ______________________________
Signature of Client Date