HARMONIC EGG of VA, LLC

732 Thimble Shoals Blvd, Suite: 906, Newport News, VA 23606

CONFIDENTIAL CLIENT APPLICATION

Client Name:____

Email:______________________ **Height:**_____ **Weight:**_____ **DOB:**__________

Telephone Home: ______________ **Work:**______________ **Cell:**______________

Address:_______________**City:**_____________ **State:**________ **Zip Code:**________

Emergency Contact:_______________ **Relation:**__________ **Phone:**______________

Relationship Status: ***Single*** ***Married*** ***Partner*** ***Separated*** ***Divorced*** ***Widow*** ***Widower***

Spouse/Partner Name:_________________________ **# of children**__________

Occupation:___________________________ **Do you enjoy your job?** ***Y*** ***N***

Primary Reason for seeing us:____________________________________

Have others helped you with the problem:____________________________

What are your expectations after the sessions:_________________________

Who can we thank for your being here (*who referred you*): Name:______________________

Telephone Work:________________________ Cell:________________________

Address:___________________City:______________ State:_______ Zip Code:________

Email:____

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METABOLISM

__Weight Gain
__Weight Loss
__High/Low BP
__Blood sugar
__Thyroid

DENTAL

__Tooth Problems
__Root Canals
__Amalgam Fillings
__Difficulty chewing
__TMJ

EYES/EARS/MOUTH

__Headaches
__Dizziness
__Ringing in Ears
__Blurred Vision
__Sinus Problems
__Difficulty Swallowing
__Mouth Sores

FEMALE

__Pregnant
__Problems w periods
__Cancer
__Breast Tenderness

NEUROLOGIC

__Numbness or Tingling
__Weakness
__Insomnia
__Poor Balance

ALLERGIES

__Medications
__Chemicals
__Foods
__Plants

CHEST

__Chest Pain
__ Palpitations
__Cough
__Shortness of breath
__Asthma

IMMUNE

__Chronic Fatigue
__Fibromyalgia
__Yeast Infections
__ Past viral infections
__ Past Strep or Mono
__ Epstein- Barr
__ Lyme

URINARY

__Frequent Urination
__Difficulty starting Uri nation
__Urinary Incontinence

STRUCTURAL

__Arthritis
__Bursitis
__Osteoporosis
__Foot/Ankle Swelling
__Blood Clots/Phlebitis
__Varicose Veins injec-tion under skin
__Recent Surgery
__Neck Pain/Problems
__Back Pain/Problems
__Sciatica

MALE

__ Prostate
__ Cancer

DIGESTION

__Heartburn
__Abdominal Pain
__Gas/Bloating
__Diarrhea
__Constipation
__Blood in stool
__History of Ulcers
_Colitis
_Liver Disease

SKIN

__Rash
__Eczema
__Dry Skin
__Acne
__ Recent Botox
__Any Recent Substance injection under the skin

Medications, Herbs, Supplements (list name, dose, and purpose)

______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

We recommend **Drinking 90 - 128 ounces of Water** daily starting on the day before your first session and for the days of integration. Do you expect any difficulty with this? **Y N**

Explain:____

How Much Do You Use:

Alcohol______________ Tobacco ____________ Coffee/Tea ____________ Drugs/Marijuana____________

Injuries/Accidents? **Y N** When & Describe______________________________

Traumatic life Events leading to any illness:______________________________

Toxic Exposures:______________________________ Date:__________

Describe Other Medical Conditions that we should be aware of**:**______________________

__Cancer __Heart Problems __Stroke ___Seizures __Diabetes __MS Other:______________

Areas in body of Complaint or tension:______________________________

Surgeries with Dates (*include location of metal plates/rods/screws*)______________________

____

Family Medical History: __Diabetes __Heart Problems __High BP __Cancer __Alzheimer's

Other:____

Current **Pain Level** (1=very low, 5=very high): 1 2 3 4 5 Explain:______________________

Current **Stress Level** (1=very low, 5=very high): 1 2 3 4 5 Explain:______________________

Current **Energy Level** (1=very low, 5=very high) 1 2 3 4 5 Explain:______________________

Describe any specific medical attention or assistance you will need while visiting our center (you must be able to get into the unit or bring a caregiver to help you).____

Will you be bringing a caregiver, nurse or spouse with you?____

Please circle the word that best describes your current state of health:

Excellent **Good** **Average** **Improving** **Declining** **Serious** **Debilitated**

What brings you joy?____

Please circle the most emotional draining relationship or relationship in your life:

Significant Other **Job** **Children** **Your Relationship with Yourself** **State of the World**

Is your home environment peaceful or stressful most of the time?__________________________________

Do you have trouble concentrating, or 'brain fog'? **Y N** Do you feel supported? **Y N**

What drives you, inspires you, gives you a sense of purpose:____

Please check the emotions that best reflect how you feel most of the time:

__Joy **__Sad** **__Excited** **__Optimistic** **__ Anger** **__Depressed** **__Passionate**

__Calm **__Alone** **__Happy** **__Blissful** **__Afraid** **__Frustrated** **__Terrified**

__Safe **__Anxious** **__Despair** **__Resentment** **__Hopeless** **__Peaceful**

Do you adhere to any particular diet?____

How many hours of sleep do you get on average? _______ Do you drink filtered or purified water? **Y N**

Describe your exercise/activity routine:____

Are you sensitive to light / loud noise? **Y N** If Yes, please explain________________________________

Are you in fear regarding your health?____

Regaining well being requires a strong personal commitment. How ready are you to make the lifestyle changes, the diet changes and the attitude changes that may be necessary to good health?

Ready **Somewhat** **Not looking to make changes**

I have read the above information and have filled out the form to the best of my knowledge. I understand that the questions on this form are being asked in order to better access my current circumstances and their relationship to my well-being. I further understand that I am voluntarily agreeing to have a relaxation therapy session and that no medical claims or promises of healing have been given.

Signature:____________________________________ **Date:**______________