



1. Client Details

Date:

Last Name		First Name	Title
Date of Birth	Age	Biological Gender	
Occupation		Email	
Home Number		Cell Number	
Home Address			
			Zip
Work Address			
			Zip

2. Person Responsible for Account

Name(s)		Relationship
Address		
		Zip
Home #	Work #	Cell #

3. Referred by / How did you hear about the practice?

<input type="checkbox"/> Family/Friend Referral Name:	<input type="checkbox"/> Physician Referral Name:
<input type="checkbox"/> Facebook/Other	<input type="checkbox"/> Holistic/Organic Supporting Facilities Name:
<input type="checkbox"/> Internet Search	<input type="checkbox"/> Other:
<input type="checkbox"/> Sign/Advertisement	

The purpose of this questionnaire is to assist you in identifying the sources and causes of your health challenges. As such, it focuses on questions relating to any symptoms you may be experiencing, lifestyle, treatments and conditions you have been diagnosed for. Answer all questions as best as you can to assist us in helping you on your path towards restored and better health.

Blood Type: (circle one) **A B AB O**

4. Current Medication & Supplements

Medicine	Daily dosage	Date started
Medicine	Daily dosage	Date started
Medicine	Daily dosage	Date started
Medicine	Daily dosage	Date started
Medicine	Daily dosage	Date started
Medicine	Daily dosage	Date started
Supplement	Daily dosage	Date started
Supplement	Daily dosage	Date started
Supplement	Daily dosage	Date started
Supplement	Daily dosage	Date started
Supplement	Daily dosage	Date started
Supplement	Daily dosage	Date started

List additional medications/supplements on the back page

5. Main Complaint(s)

a)	When did it start?
How often do you experience the symptom?	
What relieves and aggravates the condition?	
b)	When did it start?
How often do you experience the symptom?	
What relieves and aggravates the condition?	
c)	When did it start?
How often do you experience the symptom?	
What relieves and aggravates the condition?	
d)	When did it start?
How often do you experience the symptom?	
What relieves and aggravates the condition?	

If more space is needed please use the back

6. Medical History

Diagnosis	Date diagnosed	Current <input type="checkbox"/> / Previous <input type="checkbox"/>
Diagnosis	Date diagnosed	Current <input type="checkbox"/> / Previous <input type="checkbox"/>
Diagnosis	Date diagnosed	Current <input type="checkbox"/> / Previous <input type="checkbox"/>
Diagnosis	Date diagnosed	Current <input type="checkbox"/> / Previous <input type="checkbox"/>
Allergies:		

7. Surgical History

Surgery	Date performed
Surgery	Date performed
Surgery	Date performed

8. Family Medical History

Father
Mother
Grandfather (paternal)
Grandmother (paternal)
Grandfather (maternal)
Grandmother (maternal)
Siblings
Children

9. General Health

Energy levels (please rate): excellent <input type="checkbox"/> good <input type="checkbox"/> fair <input type="checkbox"/> poor <input type="checkbox"/>	Lowest at _____ (time)
Sleep (please rate): excellent <input type="checkbox"/> good <input type="checkbox"/> fair <input type="checkbox"/> poor <input type="checkbox"/>	Number of hours:
Appetite (please rate): good <input type="checkbox"/> poor <input type="checkbox"/>	Number meals per day:

10. Diet & Digestive System

(Please specify how often the following foods are consumed per week)			
Alcohol	Bread	Herbal tea	Cheese
Coffee	Fried foods	Fruit	Junk foods
Meat	Milk	Snack foods	Soft drinks

Sugar	Vegetables	Water	Wheat
Do you experience any of the following?			
Bloating	Nausea	Heartburn	
Constipation	Diarrhea	Other	

11. Additional Symptomatic Issues

Do you experience any symptoms in the following areas?	
Menstrual Cycle	Details
Urinary Tract	Details
Sexual Function & Libido	Details
Dizziness	Details
Head	Details
Eyes	Details
Mouth	Details
Ears, Nose, Throat	Details
Chest	Details
Joints / Limbs	Details
Skin	Details
Stress Levels	Details
Other:	

12. Additional Health Information

Pregnant	Yes	No
Nursing	Yes	No
Pacemaker	Yes	No
Organ Transplant	Yes	No
Cigarette Usage	Yes	No
If Yes – What is the frequency of use?		
Have you received the COVID Vaccine?	Yes	No
If Yes – When did you receive the initial vaccination?		
-- Have you received any booster shots and if so, when were they administered?		

<p>Are there other vaccinations you have received that you have concerns about? If yes, please list vaccine type & date received.</p>	<p>Yes</p>	<p>No</p>
<p>Are you currently using contraception? If yes, what form and duration of use?</p>	<p>Yes</p>	<p>No</p>

13. Checklist

- Fill out New Client Medical History form
- Hydrate before appointment (especially important for live blood analysis)
- Bioenergetic Clients Only:** Stop taking any supplements 24-48 hours before appointment (DO NOT stop taking your prescribed medications)
- Bioenergetic Clients Only:** Bring any supplements or medications you are already taking or want to have tested. (prescriptions, multivitamins, pro-biotics, herbs, etc.)
- Bring any other pertinent information not listed on this form (current lab or blood work results)

DISCLAIMER

The QEST4 system provides a completely non-invasive method for gaining valuable information about an individual's Innate Intelligence and/or energetic field. The primary objective of the evaluation is to disclose energetic imbalances and provide feedback that will assist in developing a program to support each physical and energetic system of the body.

- I give my permission for the Certified Analyst Practitioner to evaluate me with the Qest4 protocol. I understand that he/she will provide further information and education about my body's energetic fields and make recommendations based on the Qest4 evaluation.
- I understand that the Analyst Practitioner will not make recommendations pertaining to my prescribed medications. Any decision to follow through with the recommended Qest4 protocol is my own decision and will not hold the Analyst Practitioner or Bioenergetic Health USA liable.
- I understand that the Assessment is based on my own innate intelligence and how it communicates with the Qest4's quantum physics.
- I acknowledge the Qest4 Assessment targets bioenergetic signatures that are imbalanced and helps discern the root cause of health issues. I understand this is not conventional medical protocol and not termed as 'treatment, diagnoses, disease or cure'.
- I understand that I am here to learn about natural health protocols and better lifestyle practices.
- I understand that I should first discuss any alterations to my prescribed medications, including supplements, with my MD and that the Analyst Practitioner and Bioenergetic Health USA are not held liable, in any way, based on medication changes and/or supplements due to my own decision.
- I am not on this visit, or any subsequent visit, acting as an agent of the state, county, city, local law enforcement, or news media for the purpose of entrapment or investigation.
- I am not pregnant, nor have a pacemaker.
- I am able to fully comprehend, make my own decisions, and act on my own accord.

 Client Signature

 Date

 Guardian Signature (if under 18 years of age)

 Relationship