Virginia Beach Harmonic Egg LLC

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Ph: **757-288-8412. -** Website: **VBHarmonicEgg.com**

CONFIDENTIAL CLIENT APPLICATION

**Client Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**:\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code**:\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Spouse/Partner Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of children\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your 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:\_\_\_\_\_\_\_\_*

Please tick each one that applies.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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  Urination.  \_\_Urinary  Incontinence | **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 | **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 |  |  |

**Medications, Herbs, Supplements** (list name, dose, and purpose) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 issue 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 \_\_Terrified \_\_Calm \_\_Sad \_\_Resentment \_\_Alone \_\_Excited \_\_Hopeless \_\_Happy \_\_Optimistic \_\_Safe \_\_Blissful \_\_ Anger \_\_Anxious \_\_Afraid \_\_Depressed \_\_Passionate \_\_Peaceful \_\_Despair \_\_Frustrated

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_