BioSync® Client Intake Form

The practical approach to unfoldment.

You ought not to attempt to cure
eyes without head, or head without body,
so you should not treat body without soul.
- Socrates

Client Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work phone _____

Cell phone _____ Email Address _____

Referred By _____

The BioSync methods (BioSync, BioSync iCore and/or BioSync Barefoot) are not involved in treatment or diagnosis of disease, nor does it substitute for medical treatment when such attention is needed, desired or required. BioSync Consultants and Practitioners do not treat, prescribe, or diagnose an illness or any other physical or mental disorder. Nothing said or done by a BioSync Somatic Education consultant or practitioner should be misconstrued to be such. While BioSync may provide relief from physical or emotional symptoms, it is not intended to replace the advice or treatment of a licensed physician. Because bodywork should not be performed under certain medical conditions, I affirm that I have stated in this Client Intake Form all my known medical conditions and answered all questions honestly. I agree to keep the consultant or practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the consultant's part should I forget to do so.

_____ _____

Client's Signature **Date**

General Health Information

Date of Birth _____

When was your last complete physical? _____ Height _____ Weight _____

Do you have a Pacemaker? Yes / No

Have you ever received chiropractic care, massage or bodywork before? Yes / No

Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident, mental upset or unusual stress in your life? If yes, please explain.

_____

_____

_____

_____

Every disease, serious illness, accident, physical or emotional trauma and drug leaves its mark and remains as a weak point in our body's system. *BioSync* takes into account details of the past and will work to eliminate these weak points to strengthen your body. That is why it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

List all surgeries	**List all accidents**	**List any serious shock, grief, major disappointments, severe fright, nervous breakdown, or period(s) of stress overload.**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History - Check all that apply

	Stroke	Heart	Disease	Arthritis	Cancer	Diabetes	Other
Mother's Side	_____	_____	_____	_____	_____	_____	_____
Father's Side	_____	_____	_____	_____	_____	_____	_____

Current Symptoms

What is your primary reason for consulting *BioSync* today?

_____

_____

_____

Do you have pain? Y / N Is it sharp Y / N Dull Y / N Constant Y / N Intermittent Y / N
Rate your pain on a scale from 0 - 10 (0=No pain and 10=Severe Pain), please circle: **1 2 3 4 5 6 7 8 9 10**
Does your pain radiate or move? Y / N Describe:_____
What aggravates your condition/pain?_____
What relieves your condition/pain?_____
Is condition worse at certain times of the day? Y / N When?_____
Activities limited due to your condition:_____
Is condition getting progressively worse?_____
Previous doctors or treatments:_____
Any home remedies used? Y / N Explain:_____
Have you ever had same/similar condition before? Y / N Explain:_____

Check any of the following symptoms which you have now or have had in the past. N=now **P**=past

Back Pain	N / P	Leg/feet cramps at night	N / P
Broken Bones	N / P	Neck Pain or Stiffness	N / P
Bruise Easily	N / P	Numbness in Fingers/Toes	N / P
Chest Pain	N / P	Osteoporosis	N / P
Cold Hands/Feet	N / P	Panic Attacks	N / P
Contagious Diseases	N / P	Pins & Needles in Arms/Legs	N / P
Chronic Fatigue	N / P	Pregnant	N / P
Depression/S.A.D.	N / P	Roving muscle/joint pain	N / P
Dizziness/Vertigo	N / P	Severe Menstrual Cramps	N / P
Epilepsy or Seizures	N / P	Shortness of Breath/Asthma	N / P
Feeling of Anxiety	N / P	Sleeping Difficulties	N / P
Headaches	N / P	Soreness	N / P
High Blood Pressure	N / P	Stomach upset/Ulcers	N / P
Irregular Heart Rate	N / P	Stroke or Heart Attack	N / P
Irritable bowel/Colitis	N / P	Tension/Irritability	N / P

Do you have any other conditions I should be aware of?

_____

_____

_____

_____

About *BioSync*

The body, mind and spirit are interconnected components of whole health. One's optimum health potential will be reached only when a "balance" exists between these three components. Pain and disease are often "symptoms" which result from imbalance in our lives. This form will aid us in discovering symptoms which may be related to imbalances in your life. Even those who are in need of more specialized medical intervention will often benefit from the addition of *BioSync* health care.

The Body

Yes / No Do you exercise regularly?
Yes / No Do you eat properly?
Yes / No Do you consume alcoholic beverages?
Yes / No Do you consume caffeinated beverages?
Yes / No Do you smoke?
Yes / No Difficulty sleeping or falling asleep?
Yes / No Are you taking any prescriptive drugs?
Yes / No Do you take vitamins or natural remedies?

The Mind

Yes / No Do you often feel rushed?
Yes / No Do you easily lose your train of thought?
Yes / No Are you critical of yourself?
Yes / No Is it difficult to shut off or slow your thoughts?
Yes / No Are you intolerant of other's mistakes?
Yes / No Do you prefer to be in control of situations?
Yes / No Is it difficult to motivate yourself?
Yes / No Do you blame others for your feelings?

Whether we are religious or not, believe in God or a Higher Power or not, our religious or spiritual roots often have profound influences on our lives. Recent studies have demonstrated how our faith and spiritual practices affect our health. However, we also recognize that faith, religion and spiritual practices are very personal in nature. You are free to omit any question that you do not wish to answer.

The Spirit

Yes / No Do you consider yourself spiritual?
Yes / No Do you feel a strong sense of purpose?
Yes / No Are you satisfied with your life?
Yes / No Do you pray or meditate?
Yes / No Have you ever had a mystical or spiritual experience?
Yes / No Do you journal?
Yes / No Do you fast regularly?

Life Events - within the last 3 years

Yes / No Death of a Loved One
Yes / No Divorce/Separation
Yes / No Marriage/Family Additions
Yes / No Job/Career Change
Yes / No Illness of a Loved One
Yes/No Change of Residence
Yes / No Change in Financial Status
Yes / No A Difficult Relationship
Yes / No Starting/Finishing School
Yes / No Child Leaving Home
Yes / No Business Difficulties
Yes / No Conflicting goals or responsibilities

Making a significant change in any area of life requires a three step process: acquiring knowledge, making a decision, and taking action. By completing this form, you deserve to be congratulated for taking the first step toward dramatically improving your mental, physical, and emotional well being forever! I am truly delighted to work with you!

Yours In Great Health!