

ADVANCED BIOFEEDBACK CLIENT INFORMATION

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<http://advancedbiofeedback.com>

NAME:	DATE:	
ADDRESS:		
CITY:	COUNTY:	STATE:
ZIP:	DOB:	Time if known
CITY OF BIRTH:		STATE/COUNTRY
HOME PHONE:	WORK/CELL	
MALE	FEMALE	
EMAIL ADDRESS:		
OCCUPATION:	EMPLOYER:	
CITY/STATE:	ZIP:	
EMERGENCY CONTACT:		
RELATIONSHIP:	PHONE:	

Sources and Obstacles to Wellness: Please enter numbers only

OF ORGANS REMOVED: _____ PERSONAL STRESS 1-10 _____

OF CIGARETTES SMOKED DAILY _____ # OF STEROID DRUGS USED LAST YEAR _____

#GLASSES OF WATER DAILY _____ #ALCOHOL DRINKS DAILY AVERAGE _____

SYNTHETIC DRUGS USED CURRENTLY (PRESCRIPTION, OTC MEDS) _____

EXERCISE SESSIONS PER WEEK _____ #SUGAR PRODUCTS USED DAILY _____

#METAL FILLINGS IN MOUTH _____ #CAFFEINE PRODUCTS DAILY _____

#STREET DRUGS MONTHLY _____ # OF ALL KNOWN ALLERGIES _____

TOXIC EXPOSURES (RADIATION, CHEMICALS, INSECTICIDES ETC.) _____

#MAJOR PAST INFECTIONS (STREP THROAT, BRONCHITIS, PNEUMONIA ETC.) _____

MAJOR INJURIES IN PAST (SURGERIES, BROKEN BONES ETC.) _____

#UNRESOLVED MENTAL FACTORS (ANGER, FRUSTRATION, GRIEF) _____

% AMOUNT OF FAT IN DIET (1-10) _____ OVERWEIGHT POUNDS _____

RESPONSIBILITY FOR YOUR BODY (1-10)_____ (Clue-you are the only one who can be)

of Bowel Movements Daily: _____

Were you referred to me by anyone? _____

DIET: What type of diet do you eat: _____

How many fruits a day do you eat? _____ How many vegetables a day do you eat: _____

Supplements currently taking: _____

DESCRIBE YOUR OBJECTIVES IN SEEKING SERVICES HERE:

Please make sure you are hydrated prior to your appointment by drinking at least 8 oz of purified water. For distance sessions, drink plenty of good filtered water and schedule the appointment for a time when you can relax for at least 30 minutes, longer is better, without interruption. Please remove any watches and do not use electronic devices (TV remotes, computers etc) during the first 30 minutes of your session. If you have a pacemaker, are pregnant or have cancer this work is not recommended.

WAIVER – Please initial each line

___ I understand that Susan Tyler is not an allopathic doctor (MD) and does not portray herself to be. She is providing biofeedback services.

___ I understand that the services provided are for Stress Reduction, Stress Management, Muscle Re-education and Pain Management. Procedures utilized include stress reduction protocols, nutritional wellness consultation and biofeedback.

___ I fully understand Susan Tyler does not offer allopathic drugs, surgery, chemical stimulants or any other conventional treatments. **In addition, she 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.**

___ Susan Tyler does not make any claims to cure or otherwise mitigate disease. I have solicited her 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 Susan Tyler to do biofeedback testing, wellness consultation and other stress reduction protocols.

___ By signing below I acknowledge that I have read and understand all parts of the this waiver, that I had the opportunity to ask any questions with regard to the described programs, and that I hereby affirm: I am not here for medical diagnostic or treatment procedures. I am here on this and any subsequent visit solely on my own behalf.

I understand the Biofeedback equipment is FDA registered for biofeedback therapy and stress relief and is completely safe. I agree to have Biofeedback and Nutritional Counseling services provided.

 I also understand that some of the software may be considered experimental and has been used on millions of people worldwide with complete safety.

 My permission is given to utilize all of the software in this and all sessions and the practitioner may submit my data for future research to the International Review Board. No personal information will be sent.

Signature of Client (if sent via email permission is implied)

Date

Please enclose payment with your questionnaire and mail directly to me at: Susan Tyler, 268 New Bridge Rd, Glide, OR 97443 or bring with you to your session

<i>Initial Nutrition and Biofeedback Stress Reduction Session</i>	<i>\$150 (2 hour session-required)</i>
<i>Biofeedback/Stress Reduction Session</i>	<i>95.00 (1 to 1½ hour session)</i>
<i>Detox Ionic Foot Bath</i>	<i>30.00 (30 minutes)</i>

*Referrals: Receive \$10 off your next session for any paid referrals. Refer 5 clients who have paid and your next session is **FREE**. I must know you referred them ahead of time. Thank you!*

Take advantage of these SPECIAL OFFERS!

Three Discount Packages to choose from (does not include initial evaluation session):

Pay for 3 Biofeedback/Stress Reduction sessions in advance and save! **\$250.00, a savings of \$35!**

Pay for 5 Biofeedback/Stress Reduction Sessions in advance for \$399 , **a savings of \$80!**

Best buy – pay for 8 Biofeedback/Stress Reduction Sessions in advance for \$600 for a **savings of \$160 that's more than 20% off!**

Gift certificates available. Not transferable. Visa & Mastercard accepted

Missed Appointments: There is a \$25 Missed Appointment Fee if you fail to notify me at least 24 hours before your scheduled appointment.

Refunds: Full refunds if no services have yet been rendered. Refunds of any discount packages will be at the current rate for regular sessions only if any have been used.

Charge Information: Visa MasterCard Name on Card: _____

Billing Address for Card: _____

Credit Card # _____

Security Code on Back (last 3 digits) _____ Expiration Date: _____

Charge will be made from Advanced Biofeedback on your billing statement.