



LIFE VESSEL  
www.lifevesselsantafe.com

### CONFIDENTIAL CLIENT APPLICATION

Please be advised that Life Vessel sessions will not be scheduled until receipt and approval of this form.

Client: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Preferred first name: \_\_\_\_\_ Referred by: \_\_\_\_\_

Telephone Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

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

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

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship Status: Single Married Partner SameSexPartner Separated Divorced Widow Widower

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

Occupation: \_\_\_\_\_ Do you enjoy your job? Y N

Insurance Information (needed only in the event our doctor prescribes certain diagnostic tests or medications)

Are you eligible for Medicare? Y N

Name of insured (if not client) \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary reason for seeing us: \_\_\_\_\_

Health Concerns: \_\_\_\_\_

Health Goals: \_\_\_\_\_

What are your expectations? \_\_\_\_\_

Please check all conditions listed below which you have experienced: Use a P for over a year ago, Use a C for current conditions

#### METABOLISM

- Weight Gain
- Weight Loss
- High/Low blood sugar

#### DENTAL

- Tooth Problems
- Root Canals
- Amalgam Fillings
- Difficulty chewing

#### DIGESTION

- Heartburn
- Abdominal Pain
- Gas/Bloating
- Diarrhea
- Constipation
- Blood in stool
- History of Ulcers
- Colitis
- Liver Disease

#### FEMALE

- Pregnant
- Problems with periods
- Excessive Bleeding
- Breast Tenderness
- Menopausal Symptoms

#### SKIN

- Rash
- Change in mole
- Dry Skin
- Acne
- Recent Botox
- Any recent substance injection under skin

#### CHEST

- Chest Pain
- Palpitations
- Cough
- Shortness of Breath
- Asthma

#### URINARY

- Frequent Urination
- Difficulty starting urination
- Urinary Incontinence

#### STRUCTURAL

- Arthritis
- Bursitis
- Osteoporosis
- Foot/Ankle Swelling
- Blood Clots/Phlebitis
- Varicose Veins
- Recent Surgery
- Neck Pain/Problems
- Back Pain/Problems
- Sciatica

#### EYES/EARS/NOSE/MOUTH

- Headaches
- Dizziness
- Ringing in ears
- Blurred vision
- Sinus Problems
- Difficulty Swallowing
- Mouth Sores

#### NEUROLOGIC

- Numbness or Tingling
- Weakness
- Insomnia
- Poor Balance

#### IMMUNITY

- Auto Immune Condition
- Fibromyalgia
- Lymes Disease

Medications, Herbs, Supplements (List name, dose, purpose)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

We recommend drinking 128 oz (16 cups) of water daily starting on the day before your first Life Vessel session and for the next 25 days.

Do you anticipate any difficulty with this? Y N

Explain: \_\_\_\_\_

How much do you use? Alcohol: \_\_\_\_\_ Tobacco (smoke or chew): \_\_\_\_\_  
Coffee/Tea: \_\_\_\_\_ Drugs: \_\_\_\_\_

Injuries/Accidents? Y N When & Describe: \_\_\_\_\_

Traumatic life events leading to any illness: \_\_\_\_\_

Toxic Exposures: \_\_\_\_\_ Do you wear contact lenses? Y N

Any other medical conditions that we should be aware of: Describe: \_\_\_\_\_

Cancer  Heart Problems  Stroke  Seizures  Diabetes \_\_\_\_\_

Other: \_\_\_\_\_

Areas in the body of complaint or tension: \_\_\_\_\_

Surgeries with dates (include location of any metal plates/rods/screws): \_\_\_\_\_

Family Medical History:  Diabetes  Heart Problems  High Blood Pressure  Cancer  Alzheimer's Disease

Other: \_\_\_\_\_

Allergies and Sensitivities Medications: \_\_\_\_\_ Foods: \_\_\_\_\_

Plants: \_\_\_\_\_ Animals: \_\_\_\_\_ Chemicals: \_\_\_\_\_

Dates of Medical Treatment Lab Testing: \_\_\_\_\_ Pap Smear: \_\_\_\_\_ Mammogram: \_\_\_\_\_ Colonoscopy: \_\_\_\_\_

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? \_\_\_\_\_

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

Do you believe thoughts and intentions can affect your health? Y N Do you believe it is possible to change them? Y N

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 emotionally draining relationship or relationships 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 difficulty concentrating, or 'brain fog'? Y N Do you feel supported in your relationships? 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:

<input type="checkbox"/> Joy	<input type="checkbox"/> Sad	<input type="checkbox"/> Excited	<input type="checkbox"/> Optimistic
<input type="checkbox"/> Anger	<input type="checkbox"/> Depressed	<input type="checkbox"/> Passionate	<input type="checkbox"/> Terrified
<input type="checkbox"/> Resentment	<input type="checkbox"/> Hopeless	<input type="checkbox"/> Safe	<input type="checkbox"/> Anxious
<input type="checkbox"/> Peaceful	<input type="checkbox"/> Despair	<input type="checkbox"/> Calm	<input type="checkbox"/> Alone
<input type="checkbox"/> Happy	<input type="checkbox"/> Blissful	<input type="checkbox"/> Afraid	

Do you adhere to any particular diet? \_\_\_\_\_

Do you drink filtered or purified water? Y N

Describe your exercise/activity routine? \_\_\_\_\_

Do you have a meditation or relaxation practice? \_\_\_\_\_

Do you have a strong spiritual belief system? \_\_\_\_\_

Are you in fear regarding you health? \_\_\_\_\_

Do you believe that we are all individually responsible for everything that shows up in our lives, including disease & health? Y N

Do you listen to and respect your intuition? Y N

Regaining well being requires a strong personal commitment. How ready are you to truly make the lifestyle changes, the diet changes and the attitude changes that are necessary for good health? Ready      Somewhat      Not looking to make changes

Any obstacles you identify to making changes? \_\_\_\_\_

Please bring your medications, blood tests and any lab work with you.

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 in The Life Vessel/The Box™ and that no medical claims or promises of healing have been given.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Technician: \_\_\_\_\_ Date: \_\_\_\_\_