Information provided herein by you, the client, is confidential to the QEST practitioner working with you:
You may print and complete (return via email to qestherapy@outlook.com)-
Keep a copy for yourself!

QuestEnergetics CLIENT INTAKE FORM

NAME_____

CONTACT PHONE_____

ADDRESS_____

CITY_____STATE___ CIRCLE: married widowed divorced single

DATE OF BIRTH_____ AGE_____

IF CHILD, LIST PARENTS NAMES_____

E-MAIL ADDRESS_____

OCCUPATION_____

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Please use back of page if more space is needed

1. What concerns do you have regarding your current health TODAY?

2. Have you ever had head trauma (blow to the head, car accident, concussion)
If yes, please list age(s) or year(s) and describe what happened and any side effects you have experienced:

3.. Have you ever had any fractures (broken bones), sprains, or other sports or auto accidents?
If so, please list (location, age/date injury occurred, treatment)

4. List any surgery, hospitalizations, trauma(accidents): **(include dates/ages)**

5. Tell me what you know about your birth (difficulties, trauma, forceps, notable circumstances, birth weight)

6. Have you ever experienced chiropractic manipulation? **Y N**

7. Are you under a doctor's care for any reason? Y N if so please explain:

8. Are you taking any medication or supplements? **Y N Please List:**

9. Are you receiving any other kinds of healing modalities?

10. Describe your diet. (*Check the one(s) that best describe your eating pattern, and give details in the space below.*

__ heavy meat (all kinds)
__ light meat (all kinds)
__ eat chicken & fish only
__ vegetarian (no meat)
__ vegan (no meat, eggs, or milk products)
__ High processed foods
__ High sugar intake
__ Consume soda or caffeine — How much per day?

How much water do you typically drink per day?____ glasses.
Did you know that we loss 2 liters of water a day - that needs to be replaced.

11. Do you experience any of the following? **Don't use a check-mark, but if present, please indicate:**

"A"=Always "F"=Frequent "S"=Sometimes

__headaches
__stiff neck
__upper back pain
__lower back pain
__shoulder pain
__knee pain
__ankle pain
__calf pain /leg pain
__foot pain
__heel pain
__elbow pain
__hungry right after eating
__chronic fatigue
__periodontitis
__blood pressure
__trouble sleeping
__"fuzzy" headedness
__attention deficit disorder
__depression
__intestinal gas
__cysts
__abdominal distension
__craving of sugar
__gallstones
__coordination problems
__feeling of weakness
__accident-prone
__light-headedness
__panic attacks
__attention deficit disorder
__bruise easily
__menopause

__hand pain
__chest pain
__pain in area of ribs
__ringing in ears
__pain in ears
__dizziness
__PMS
__TMJ / jaw pain
__eye pain / dryness
__osteoporosis
__bladder infection
__anemia
__constipation
__high triglycerides
__ periodontitis
__trouble sleeping
__trouble focusing
__frequent colds / flu
__psoriasis
__swollen glands
__feeling "on edge"
__intestinal pain
__low blood sugar
__impotence
__tumors
__many moles / warts
__intestinal gas
__frequent colds / flu
__anxiety
__learning difficulties
__blood clots
__joint pain

__diminished sense of taste
__diminished sense of smell
__equilibrium problems
__ sciatica (pain down leg
__hip pain
__difficulty swallowing
__kidney stones
__cough
__sinus congestion
__PMS
__wrist pain
__seizures
__frequent diarrhea
__high cholesterol - LDL
__very low blood pressure
__heartburn
__discomfort eating
__learning difficulties
__hyperactivity
__discomfort after eating
__feeling of impending doom
__hemorrhoids
__sore throat
__diabetes
__fatigue
__acne/skin breakouts
__irregular periods
__blood clots
__hyperactivity
__trouble focusing / thinking
__chronic muscle pain
__frequent bloody nose

__painful abdomen
__arthritis (joint inflammation)
__dental problems/cavities
__stomach feels too full to eat
__diminished immune response
__wake up at night to urinate
__frequency of urination
__more tired after eating
__other:_____

__parasites known / suspected
__numbness/tingling fingers
__tachycardia/rapid heartbeat
__burning / pain with urination
__diminished immune response
__difficulty or painful urination
__difficulty taking deep breath
__rectal pain, fissures, bleeding

12. Do *you* have an idea about what is the cause of any of these issues—regardless of what diagnosis you received?

13. Do you have, or have you ever had: (*Please check all that apply)*

__ measles __ bronchitis __ hepatitis __ pacemaker
__ mumps __ pneumonia __ HIV or AIDS __ chemo
__ chicken pox __ scarlet fever __ heart attack __ herpes
__ radiation __ asthma __ diagnosed PTSD
__ been in a coma __ have screws/metal in your body

14. Number of pregnancies (list results) _____
Type of contraception (if applicable) _____

15. Current exercise. Please list the type and frequency of exercise. Example: running—3 x week, swimming—1 x week, weights—3 x week, Pilates, etc.

16. Have you played football, soccer or other sports? Have you grown up / worked on a farm / ranch? Have you had much experience riding horses / motorcycles?

17. Are you ambidextrous? **Y N** If yes, please give some details.

18. Do you have any allergies?

__ pets __ environmental __foods __ airborne
__ respiratory or sinus problems __ skin irritation __ other
Do members of your family have any allergies? **Y N**

19. Anything else you would like to share about what brings you here today?

Disclosure

Please read, sign and return - a copy will be retained for yourself.

1. Charlotte Ballard ("Practitioner") is not a licensed physician, and is not licensed by any state as a healing arts practitioner and that the treatments are not licensed by any state but are alternative or complementary to healing arts services licensed by the state of Texas or Colorado or any other state.

2. The services to be provided by Practitioner are not licensed by the state of Texas or Colorado or any other state.

3. I understand Quantum Energetics Structured Therapy is an energy based healing technique that utilizes "prana or chi" to balance, harmonize and transform the body's energy processes by cleansing, energizing and balancing the body's bio-electromagnetic field or aura. Charlotte Ballard uses a method of muscle testing, touch, and herbal and nutritional supplementation. Practitioner does not diagnose or treat diseases. Quantum Energetics acknowledges the physical body as a complex energy system and employs a range of techniques for evaluation and restoring balance to the body.

4. The theory of treatment upon which the services are based is as follows: the services described in 3 above can help release blocks allowing energy to flow more freely in one's life.

5. Practitioner's education, training, experience, and other qualifications regarding the services to be provided are as follows:

University of Texas, BA Sociology(1990)
University of Phoenix, MA Organizational Management(2002)
Austin Community College, Nursing Assistant Certification(2002)
Austin Community College, Phlebotomist Certification(2004)
Certification in Quantum Energetics Structured Therapy, Quantum Energetics Institute (2018-2020)
Certification in Myofascial Release I, 2020

In addition to the above disclosures, which are not required by the state of Texas or Colorado, I also understand and acknowledge the following:

6. I authorize Practitioner to use physical contact and touch as necessary for the delivery of services described in #3 above.

7. I recognize that Practitioner cannot guarantee results or any specific outcomes from our work together. I am solely responsible for any action taken based on my interpretation of any information presented.

8. I understand that Practitioner has the right to refuse to continue delivering survivors at any time for any reason whatsoever.

(disclosure continues on next page) _____initial and date
9. I am not an engaging Practitioner for any medical or psychological services. I understand that Practitioner does not diagnose or treat any medical or psychological condition, and that Practioner's services are not designed to replace conventional treatment methods of medical or psychological conditions. I am aware that health care decision-making, both physical and mental, begins with my obtaining a complete medical evaluation by my primary care health provider including current health practices in order to develop a therapeutic treatment plan which enhances my health promotion and maintenance, reduces opportunity for untoward side effects or contraindications, and safeguards my health. I am aware that mental health care issues require care by an appropriately licensed healthcare professional such as a licensed psychologist, and that Proactioner is not licensed by Texas or Colorado or any other state as a psychologist and is not delivering psychological services. I am responsible for my own health care decision-making by obtaining any necessary consultations with appropriately licensed health care professionals.

10. I understand that working with Practitioner may bring up distressing feelings, images, thoughts and behaviors. Some of these distressing experiences may persist or resurface at a later time. I agree to seek medical assistance or psychotherapy or any other appropriate physical or mental diagnosis and treatment from a practitioner duly licensed in my state (such as a licensed medical doctor or licensed psychologist) and I find that these distressing aspects create a danger for myself or for others.

11. I knowingly, voluntarily, and intelligently decide to receive the services described in paragraph 3 above, and I knowingly, voluntarily, and intelligently assume all risks involved in the same. As a result of my assumption of these risks, I agree to release, indemnify, and defend Practitioner and her agents from and against any and all claims which I (or my representatives) may have for any loss, damage, or injury arising out of or in connection with use of the services described in 4 above, or arising out of or in connection with referral to other practitioners or merchants for deliver of any services.

12. I have carefully read this form and acknowledge that I understand it. I also acknowledge that I have been provided with a copy of this form by electronic delivery and have signed to verify my receipt of the same. o representations or statements, or written, have been made to me, apart from those described in this form. If any portion of this form is held invalid, the rest of the document will continue to full force and effort.

_____ _____
Signed here *Dated*