

Quantum-Touch® Client Information Form

Printed Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

E-Mail: _____

If in pain, (emotional or physical) how would you rate your current level of pain on a scale of 1 to 10 (10 being the greatest)?

1 2 3 4 5 6 7 8 9 10

Primary concern/goal for this session? _____

Are you currently being treated by a doctor, chiropractor or other practitioner?

Yes No

If so, for what reason? _____

I certify that the above information is correct to the best of my knowledge. I will not hold the practitioner responsible for any errors or omissions that I have made in the completion of this form. I understand that this service is designed to be a health aid and is in no way to take the place of a doctor's care when it is indicated. Information exchanged during any session is educational in nature and should be used at your own discretion. All client information is held in strict confidence.

I understand that Quantum-Touch is a stress reduction and relaxation technique. I understand that the Quantum-Touch practitioner does not diagnose conditions, prescribe medications, perform medical treatment, nor interfere with the treatment of a licensed health care professional. It is recommended that I see a licensed physician, or a licensed health care professional for any physical or psychological ailment I may have.

I also understand that it is solely my responsibility and choice to use any suggestions I may receive during this session.

Signature: _____

Date: _____