Biofeedback
Client Intake Form
(Confidential)

Integrative Health Management; Adriana Krywiak DPM, CFMD, QBT

☐Female ☐Male ☐Married ☐Divorced ☐Widowed ☐Single ☐Separated

Name_____Date_____

Address_____

City_____State_____Zip_____

Date of Birth_____Place of Birth_____

Home Phone_____-_____-_____Secondary Phone_____-_____-_____

Occupation_____Employer_____

Employer Phone_____

Name of Spouse (if applicable)_____Spouse DOB_____

In case of emergency contact_____Phone_____

Secondary Contact_____Phone_____

Please fill out the following questionnaire to the best of your ability: # Equates to Number

# Of Organs Removed (tonsils, gallbladder, teeth, etc)		Personal Stress (1-10) (general stress in current day)	
# Of Synthetic Drugs Currently Used (prescribed pharmaceutical drugs)		# Of Sugar Type Products in One Day (1-10) (number of refined sugar products)	
# Of Times You Smoke in One Day (ANY consumption of nicotine/tobacco; NOT including marijuana)		# Of Exercise Sessions in One Week (but not including job/work activity)	
# Of Steroid Type Drugs Used in the Past Year (steroid based anti-inflammatories)		# Of Alcoholic Drinks Consumed Daily (Average) (any kind of alcohol drink daily)	
# Of Amalgams (Silver) Fillings in Mouth (number of any metal, nickel , gold dental fillings)		# Of Caffeine Products per Day (coffee, tea, soda, energy drinks, chocolate etc.)	
# Of Street Drugs Used Each Month (this includes marijuana or any hard drug)		# Of Toxic Exposures in the Last Year (radiation, chemicals, insecticides, pesticides, etc.)	
# Of All Known Allergies (food, inhalants, dust, drug, skin etc)		# Of Major Injuries in the Past (injuries, broken bones, spiritual, emotional, mental, financial)	
# Of Unresolved Emotional Factors (anger, depression, anxiety, abuse, fear, etc.)		# Of Major Infections in the Past (health threatening infections)	
I am responsible in caring for my body (1-10) (How well do you take care of your body, spirit etc)		# Of Glasses of Water per Day	
Amount of Fat in My Diet (1-10) including processed food		How Many LBS. Overweight	

I understand that the attending practitioners are providing bio-feedback and wellness services. I understand that the services provided identify energetic imbalances and the procedures utilized include stress reduction protocols, nutritional wellness consultation and bio-feedback. I understand that I am not being instructed to discontinue traditional medicine and that this is not meant as a replacement for my current medical treatment. I have solicited the attending practitioner's services in good faith, exercising my free will and following the decree of my own conscience which allows me to select what I understand is most beneficial to my health. I am fully aware and release the practitioner to do bio-feedback testing, wellness?/Functional Medicine consultation and other stress reduction protocols. By signing below, I acknowledge that I have read and understand all parts of this waiver, that I have been given the opportunity to ask and question all described procedures, and that I hereby affirm: I am not here for traditional medical treatment procedures and that I am here on this and any subsequent visits solely of my own accord and on my own behalf.

Client Signature_____
Date_____