QNRT WELLNESS INTRODUCTION FORM

Patients Name_____ Date_____

Address_____

City_____ State_____ Zip_____

Sex: Male Female Date of Birth_____ Age_____ Marital Status_____

Social Security#__xxx-xx-(_____) Email Address_____

Occupation_____ Employer_____

Phone (Home)_____ (Cell)_____ (Work)_____

Which number would you prefer we use to contact you?_____

In case of emergency, whom should we call?_____

Relationship_____ Contact number_____

HEALTH INFORMATION KEY

*Severity: Rate on a scale from 1-10, with 1 being no symptoms/pain and 10 being the worst its ever been.

**ADL: How does your past injury/condition affect how you function from day to day?

0-does not effect 1-minimally effects 2-moderately effects 3-severly effects

PRESENT HEALTH INFORMATION

	Symptom	Treatment (If any)	Onset	Current Severity* 1-10	ADL** 0-3

PAST HEALTH INFORMATION

	Symptom	Treatment (If any)	Onset	Original Severity* 1-10	Current Severity* 1-10	ADL** 0-3

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FAMILY HISTORY: Identify any conditions that you or any of your family members have now or have had in the past:
(G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

__Alcoholism
__Attention Deficit Disorder
__Cancer
__Cirrhosis
__Celiac's Disease
__Alzheimer's Disease
__Migraine Headaches
__Arthritis
__Eczema
__Emphysema
__Epilepsy
__Crohn's Disease
__High Blood Pressure
__Heart Disease
__Diabetes
__Anxiety Disorder
__Miscarriage(s)
__Thyroid Issue
__Kidney Disease
__Pneumonia
__Hyperlipidemia
__Multiple Sclerosis
__Strokes
__Obesity
__Demetia
__Anemia
__Eating Disorder
__Depression
__Schizophrenia
Other:_____
_____
_____

ALLERGIES: Please check and list all allergies you currently may be suffering from:
***Allergy Types:** **Food** **Medication** **Seasonal** **Environmental**

Allergy Type*	Allergy Name	Onset

Supplements: (Please choose a type for each supplement-to list more, please use the back of this form)
Herb* Vitamin* Mineral* Amino Acid* Homeopathic* Tincture* Multi-Vitamin* Food Concentrate* Hormone* Fatty Acid*

Supplement Type*	Supplement Name	How Long?

Medications: Please check and list all the medications that you are currently taking with the dates you began taking them

Medication Type	Medication Name	Start Date
Antacids		
Antibiotics		
Anti-Depressants		
Anti-Diabetics		
Anti-Inflammatory		
Blood Pressure Medications		
Cholesterol Lowing Medications		
Hormone Replacement (HRT)		
Oral Contraceptives		
Other		

Scars/Surgical Procedures: List all scars and surgical procedures you have had

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Location of Scar:	Result of:	Onset

Habits:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda/Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

Healty Habits					
Exercise	5-7/wk ☐	3-5/wk ☐	1-3/wk ☐	None ☐	Type of Exercise _____
Sleep	8+hours ☐	7-8 hours ☐	6-7 hours ☐	5-6 hours ☐	<5 hours ☐
Meals/day	5+ ☐	4 ☐	3 ☐	2 ☐	
Water/day	64+oz ☐	32-64oz ☐	16-32oz ☐	<8oz ☐	

Work Activity

☐ Heavy labor ☐ Light labor ☐ Mostly sitting

☐ Mostly standing ☐ Walking/Standing ☐ Driving

BODY/MIND BALANCED
WELLBEING

(Please turn over and complete the last page)

QNRT WELLNESS INTRODUCTION FORM

Quantum Neuro Reset Therapy™
Body/Mind Balanced Wellbeing and Dr. Michael Goad
Therapeutic Practitioner

Informed Consent, Private License and Release

The undersigned hereby grants a **Private License** to the Practitioner to provide the Quantum Neuro Reset Therapy™ services to undersigned as expressive association activities. I acknowledge that I am not receiving these services as a patient of Dr. Michael Goad's chiropractic practice.

The undersigned acknowledges that the Therapy does not diagnose or prescribe for chiropractic, medical or psychological conditions nor claim to prevent, treat, mitigate or cure such conditions. The Practitioner while utilizing QNRT™ does not provide diagnosis, care, treatment or rehabilitation of individuals, nor apply medical, mental health or human development principles, but rather provides a Reset Therapy that may offer therapeutic benefit by supporting normal structure and function. The undersigned gives Informed Consent to the services that will be provided. The undersigned hereby releases the Practitioner from all claims and liabilities arising from the use or misuse of the Quantum Neuro Reset Therapy, indemnifying and holding the Practitioner harmless from all claims and liabilities there from whatsoever. The Practitioner reserves all rights.

Signature: _____Date:_____

Print Name: _____

MINOR CONSENT

Being the parent or legal guardian of _____ (minor's printed name),

I _____ (parent/guardian's printed name) do consent and grant a **Private License** to the Practitioner to provide Quantum Neuro Reset Therapy services as noted above in the informed consent, Private license and Release statement to be performed for the minor child. I further understand that the doctors and other providers attending to my child will take all reasonable safety precautions during their care.

Minor's date of birth: _____

Parent/Guardian Signature: _____Date:_____