

Client Intake Form (option)

OBERON RESEARCH

Address
City, State Zip
Phone #

ANALIZING STRESS IN THE BODY
BIO-FEEDBACK QUESTIONARE

NAME _____ REFERRED BY _____

ADDRESS _____

E-MAIL _____

PHONE _____ FAX# _____ CELL PHONE _____

BIRTHDATE _____ PLACE OF BIRTH _____

ORGANS REMOVED (INCLUDING TEETH) _____

NAMES OF DRUGS CURRENTLY BEING USED

LIST DIET SUPPLEMENTS _____

PLEASE LIST ANY AREAS OF CONCERN

TECHNICIAN UNDERSTANDING OF CLIENT FORM (optional):

Answer any that apply with a number

- ____ Number of organs removed
 - ____ Number of synthetic drugs used currently
 - ____ Amount of times you smoke (chew) per day (tobacco)
 - ____ Number of steroid type drugs used in the past
 - ____ Number of dental fillings NOT porcelain present (including removed within last year)
 - ____ Number of street drugs used per month
 - ____ Number of all known allergies
 - ____ Number of unresolved mental factors
 - ____ Responsibility for your dis-ease on scale of 0 (min) to 10 (max)
 - ____ Amount of fat in diet as % incl. processed food (national average is 40%)
 - ____ Personal stress 0-10 (10 max)
 - ____ Number of sugar type products per day (Including soft drinks, ice cream, etc.)
 - ____ Number of exercise sessions per week, at 20 minutes or more (not work)
 - ____ Number of alcoholic drinks per day on average
 - ____ Number of cups of coffee, tea or caffeine products (chocolate) per day
 - ____ Number of extreme toxic exposures per year (radiation, insecticide, chemicals, chemo
Frequency balancing, etc.)
 - ____ Number of major injuries and surgeries (incl. emotional traumas) from past
 - ____ Number of major infections
 - ____ Number of water or natural fruit juice drinks per day
 - ____ How many kilos overweight 1kilo = 2.2 lbs.
- List any stress types (job, family, home, relatives, emotions, etc.) _____

List any inherited disorders _____

Please check any that apply

- Vascular or circulatory dis-ease, cold extremities, artery or vein problems
- Infection or history of infections
- Neoplasm, possibility of cancer, tumor, or degenerative dis-ease
- Dietary problems, possible addiction to drugs or toxic exposure
- Intoxication or possible addiction to alcohol
- Congenital disorder, hereditary or from birth
- Allergy tendency or prevalence of allergic symptoms in history
- Endocrine disturbance, hormonal, glandular, or regulatory problems
- Emotional problems related to the client's concerns
- Stress related to the problems of the client
- Sensory (eyes, ears, taste, feeling, smell) problems in client's history
- Adverse reaction to excess humidity, heat, cold, dryness, wind, or radiation
- Lack of awareness, need for education

Toxic Exposures:

- Beauty shop toxins or similar
- Asbestos from shipping, industry, insulation, etc.
- Insecticides, herbicides, industrial farm chemicals
- Heavy metals
- Food additives
- Radiation
- Chlorine or fluoride sensitivity
- Environmental toxins of water and air pollution
- Exposure to infections

Wellness & Bio-Feedback Research and Training Consultation Waiver

1. I fully understand that the attending technician is not an allopathic practitioner (MD) and does not portray his/her self to be one, but is a wellness consultant and Bio-Feedback technician.
2. I fully understand the difference between the practice of allopathic (conventional) medicine, nutritional wellness consulting, and Bio-Feedback.
3. I fully understand that the services provided by the attending technician are not allopathic, but are strictly behavioral, stress or Bio-feedback in nature.
4. Any reference to patient within this Frequency balancing is solely due to the technical terminology within the OBERON program and in no way implies that the client is a medical patient.
5. I fully understand that the attending technician performs his/her services within the parameters of a natural health care and wellness system using Bio-Feedback and stress reduction.
6. I fully understand that the attending technician does not offer allopathic drugs, surgery, chemical stimulants, radiation Frequency balancing, or any other conventional treatments. In addition, he/she does not diagnose, treat, or otherwise prescribe for any disease, condition, or illness, and that my wellness and stress parameters are being measured.
7. I have solicited the attending Bio-Feedback technician's services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health.
8. I also exercise my free will in asking this business and technician for their opinion on items and situations which may expedite my good health; it is my choice should I accept to utilize or apply any of those ideas or suggestions at any time.
9. If I desire any services not provided by the attending Bio-Feedback technician, which is my prerogative, I fully understand that I should seek them elsewhere. A referral for such services can be arranged.
10. I presently seek counsel, advise, opinions, Bio-feedback or points of view and/or programs within the scope of the attending technician's wellness and stress reduction practice. I am fully aware and release the Bio-feedback technician to do Bio-feedback stress interpretations and frequency balancing.
11. I fully understand that the services provided by the attending technician are not generally accepted and/or recommended by allopathic doctors (MD's) or other conventional health care professionals. I realize that insurance payment may be possible, but is highly unlikely.
12. I understand that payment is expected at the time of service, unless otherwise arranged prior to my scan.
13. I understand that I must call and cancel an appointment at least 6 hours prior to my scheduled appointment time. If I do not show up for an scheduled appointment I will be charged full rate for that time.
14. By signing below, I acknowledge that I have read and understand all parts of this waiver and that I have had the opportunity to ask any questions with regard to all such procedures.
15. The Food and Drug Administration have not evaluated these statements. This product is not intended to diagnose, treat, cure or prevent any disease.

16. I understand that it is my responsibility to present myself when observing or participating this session, when employed by the FDA or any other governmental agency.

Signature _____ Date _____

