Cleansing Flow™ Consultation

Date: _____

Client: _____ **Referred by:** _____

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Email: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

1. **What is your health issue?** _____
2. **How long have you had it?** _____
3. **Has it been diagnosed by a doctor? Yes or No (circle one)**
   If so, when _____
4. **Why do you want to get well?** _____
5. **Do you believe there was an event(s) that triggered your condition? Yes or No (circle one)**
   If so, what?
6. **Do you drink soda pop? If so, what kind** _____
7. **What are your symptoms and conditions?** Note: If helpful, use page 2 "Chronic Symptoms and Conditions" and check all that apply. Or use the space below and if you need more room write on the back of page 2.
8. **Which one or two symptoms or conditions bother you the most right now? And why?**
9. **Are you currently taking drugs, herbs or supplements? If so, please fill out page 3 "Current Medications"**
10. **What treatments have you had for this health issue, symptoms and conditions?**
    ☐ **Trigger Point Injections (e.g., prolotherapy)** ☐ **Acupuncture** ☐ **Aerobic Exercise** ☐ **Chiropractic**
    ☐ **Cognitive/Behavioral Therapy** ☐ **Craniosacral Therapy** ☐ **EEG-Based Stimulation** ☐ **Massage**
    ☐ **Myofascial Release** ☐ **Trigger Point Therapy** ☐ **Nutrition Therapy** ☐ **Physical Therapy**
    ☐ **Occupational Therapy** ☐ **Postural Training** ☐ **Relaxation Therapy** ☐ **Stretching (Yoga)**
    Another Energy Therapy _____ **Other** _____
11. **Is there anything else you would like to tell me?**

Cleansing Flow™ Consultation
Chronic Symptoms and Conditions

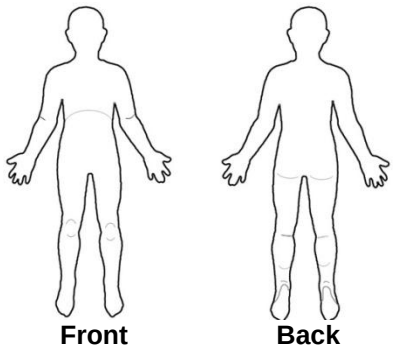
Client: _____

Date: _____

✓ Check all symptoms and conditions that apply

Musculoskeletal

- ☐ **Widespread Pain**
  Pain sensations can include: burning, grabbing, stabbing, stinging, throbbing, twitching, prickling, and pulsing
- ☐ **Stiffness**
  - — Worse in AM
  - — Worse with Prolong Periods of Standing/Sitting
- ☐ **Jaw Issues**
  - — TMJ (Temporomandibular Joint) Dysfunction
  - — Sensitivity, Tingling, etc…
- ☐ **Leg Sensations**
  - — Restless Leg Syndrome (RLS)
  - — Irresistible Urge to Move Legs
  - — Feeling of Electrical Impulses
- ☐ **Other Musculoskeletal Trouble Areas**
  Mark with "X" below



Front **Back**

Dermal

- ☐ **Hurts to Wear Clothes**
- ☐ **Crawling Feeling**
- ☐ **Itching/Rashes (many varieties)**
- ☐ **Burning**
- ☐ **Swollen & Hot Itching**
  - — Palms
  - — Soles of Feet
- ☐ **Patches of Pimples**
- ☐ **Perspiration is Pungent & Irritates the Skin**
- ☐ **Dryness, Scalded or Metallic Mouth Sensation**
- ☐ **Blurring Vision**
  - — Eye Irritation
  - — Blurring with a Discharge
  - — Blurring with Burning Eyes
- ☐ **Brittle Nails**
- ☐ **Inferior Hair Quality & Dryness**

Cerebral

- ☐ **Fatigue**
  - — Mild Tired Feeling
  - — Total Exhaustion/Flu Like
- ☐ **Irritability**
- ☐ **Anxiety or Nervousness**
- ☐ **Depression**
- ☐ **Impaired Memory & Concentration**
- ☐ **Feeling Overwhelmed**
- ☐ **Apathy**
- ☐ **Frequent Awakening During the Night**
- ☐ **Non-Restorative Sleep**
- ☐ **Dizziness**
  - — Light Headedness
  - — Balance Problems (vertigo)
- ☐ **Headaches**
  - — Migraines
- ☐ **Transient Ringing (or other sounds) in Ears (Tinnitus)**
- ☐ **Increased Sensitivity (i.e., hyperactive nervous system)**
  - — Sounds
  - — Bright Lights
  - — Smells
  - — Chemicals
  - — Chilled or Feverish
- ☐ **Non-Allergic Rhinitis**
  - — Nasal Congestion
  - — Excessive Nasal Discharge (mucus)
  - — Sinus Pain

Gastrointestinal

- ☐ **Nausea**
- ☐ **Acid Reflux (hyperacidity)**
- ☐ **Irritable Bowel Syndrome**
  - — Gas
  - — Pain
  - — Bloating
  - — Constipation
  - — Diarrhea

Genito-Urinary

- ☐ **Vulvar Pain**
- ☐ **Vaginal Spasms or Cramps**
- ☐ **Burning Discharge**
- ☐ **Increased Menstrual & Uterine Cramps**
- ☐ **Painful Intercourse (dyspareunia)**
- ☐ **Repeated Bladder Syndrome (no infection)**
  - — Increased Frequency
  - — Increased Urgency
- ☐ **Pungent, Concentrated Urine**
- ☐ **Chronic Interstitial Cystitis (IC) of the Bladder**

Cleansing Flow™ Consultation
Current Medications

Client: _____

Date: _____

Name	Dosage/Freq.	Reason	Date Started	Side Effects	Notes:
Prescriptions Drugs:					
Over-the-Counter Drugs:					
Homeopathic Remedies, Herbal Remedies and Dietary Supplements					