Date: _____

QUANTA™ Therapies

Patient Information Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: ☐ M ☐ F ☐ Trans* Date of Birth: _____ Day Phone: _____

Email: _____

In case of emergency (*name & phone number*): _____

Health Information

The symptoms below may relate to your current condition. Please check if you are currently experiencing or if you have ever experienced a particular symptom.

GENERAL

- ☐ Abnormal weight loss
- ☐ Abnormal weight gain
- ☐ Alcoholism/drug abuse
- ☐ Allergies
- ☐ Blood/bleeding problems
- ☐ Breast lumps/soreness
- ☐ Cancer
- ☐ Depressions/anxiety
- ☐ Diabetes
- ☐ Excessive thirst
- ☐ Fever/chills without flu
- ☐ General fatigue
- ☐ Night sweats
- ☐ Poor sleep
- ☐ Thyroid disease/goiter

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Appendicitis
- ☐ Belching/gas
- ☐ Black/bloody stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallbladder problems
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Liver problems/jaundice
- ☐ Frequent nausea/vomiting
- ☐ Pain over abdomen
- ☐ Poor appetite
- ☐ Poor digestion
- ☐ Ulcer/heartburn

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Pain between shoulders
- ☐ Low back pain
- ☐ Hip/knee/ankle/foot pain
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Shoulder/elbow/wrist/ hand pain
- ☐ Scoliosis

CARDIORESPIRATORY

- ☐ Ankle swelling
- ☐ Asthma/wheezing
- ☐ Chest pains
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ High blood pressure
- ☐ High cholesterol levels
- ☐ Irregular heartbeat
- ☐ Previous heart trouble
- ☐ Rheumatic fever
- ☐ Spitting phlegm/blood
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Varicose veins

SKIN

- ☐ Bruising easily
- ☐ Change in mole/s
- ☐ Itching/eczema/rash
- ☐ Skin cancer

GENITOURINARY

- ☐ Blood in urine
- ☐ Difficulty starting flow
- ☐ Frequent day urination
- ☐ Frequent night urination
- ☐ Inability to control flow
- ☐ Kidney disease/stones
- ☐ Painful urination
- ☐ Sexual difficulties
- ☐ Urinary tract infection
- ☐ Venereal infection

WOMEN ONLY

- ☐ Endometriosis
- ☐ Excessive menstrual flow
- ☐ Irregular cycles
- ☐ Hot flashes
- ☐ Painful periods
- ☐ PMS
- ☐ PCOS
- ☐ Fibroids
- ☐ History of migraines
- ☐ Hair loss
- ☐ Low sex drive
- ☐ Pregnancy-# of births ___
- ☐ Vaginal burning/itching
- ☐ Last period began _____
- ☐ Last PAP test _____

MEN ONLY

- ☐ Testicular swelling/pain
- ☐ Prostate cancer

NEUROLOGICAL

- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Mental disorder
- ☐ Numbness/tingling
- ☐ Twitching/tremors
- ☐ Epilepsy
- ☐ Weakness

EYE, EAR, NOSE & THROAT

- ☐ Deafness/difficulty hearing
- ☐ Dental problems
- ☐ Ear noises/ringing
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Nose problems
- ☐ Pain in/behind eyes
- ☐ Sinus problems/hay fever
- ☐ TMJ
- ☐ Tonsil problems
- ☐ Visual disturbances

IMMUNE SYSTEM

☐ YES ☐ NO Have you ever had asthma, allergies or acid reflux?
☐ YES ☐ NO FEMALES: Have you ever had endometriosis? If YES, since when? _____
☐ YES ☐ NO Have you ever been diagnosed with an autoimmune disease?
☐ YES ☐ NO Have you ever been diagnosed with a virus? (i.e. Mono, Epstein-Barr, Herpes, chickenpox/shingles?)
☐ YES ☐ NO When stressed, do you experience: cold sores, shingles or chronic fatigue?

HORMONE

☐ YES ☐ NO Any sleep disturbances? If YES, please explain:_____
☐ YES ☐ NO When you wake up in the morning do you feel energized?
☐ YES ☐ NO Do you feel you want to sleep longer?
☐ YES ☐ NO Do you feel tired regardless the amount of hours you sleep?
☐ YES ☐ NO Do you get cravings for sugar OR salt?
☐ YES ☐ NO Do you have difficulty losing and/or gaining weight regardless of diet/exercise regimen?

THYROID

☐ YES ☐ NO Do you get cold hands/feet?
☐ YES ☐ NO Do you easily gain weight?
☐ YES ☐ NO Do you experience constipation?
☐ YES ☐ NO Do you have history of high cholesterol?

BLOOD SUGAR

☐ YES ☐ NO Have you ever been diagnosed with Diabetes?
☐ YES ☐ NO Do you frequently get thirsty?
☐ YES ☐ NO Do you frequently feel the urge to urinate?
☐ YES ☐ NO Do you feel tired/fatigued after a meal?
☐ YES ☐ NO Do you feel energized after a meal?
☐ YES ☐ NO Do you feel "hangry" in the morning before breakfast?

TESTOSTERONE (for Males)

☐ YES ☐ NO Do you urinate frequently and/or have difficulty urinating?
☐ YES ☐ NO Do you suffer from baldness?
☐ YES ☐ NO Do you have difficulty gaining muscle weight when working out?
☐ YES ☐ NO Do you have difficulty losing weight?
☐ YES ☐ NO Do you experience low sex drive?

DIGESTION

☐ YES ☐ NO Do you experience gas and/or bloating after eating?
☐ YES ☐ NO How do you feel after taking probiotics? Any problems? If YES, explain: _____
☐ YES ☐ NO Have you been diagnosed with stomach ulcers or gastritis?
☐ YES ☐ NO SIBO?
☐ YES ☐ NO Candida?
☐ YES ☐ NO Depression?
☐ YES ☐ NO ADHD?

SKIN

☐ YES ☐ NO Do you experience skin itching/irritation frequently?

☐ YES ☐ NO Have you recently been experiencing food sensitivity/allergies to food not previously experienced?

Do you have any skin conditions such as:

☐ YES ☐ NO Psoriasis?

☐ YES ☐ NO Eczema?

☐ YES ☐ NO Rosacea?

☐ YES ☐ NO Acne?

☐ YES ☐ NO Other: _____

GENERAL

List any medications you are taking (prescribed and over the counter):_____

_____

_____

_____

_____

What do you take them for? _____

Do they help you with your symptoms? _____

List any history of surgeries? _____

_____

_____

_____

_____

Are there any other comments you wish to add?_____

_____

_____

_____

_____

Date: _____

Liability Waiver

I have completed this form to the best of my ability. I understand that The Quanta instructor is relying upon this information to make treatment recommendation.

WAIVER OF LIABILITY: In consideration of participation in a class, activity or therapy offered by The Quanta instructor, I, the undersigned for myself, agree to indemnify and hold The Quanta instructor harmless and hereby waive, release and discharge any and all claims for damage, for death, personal injury, bodily injury or property damage which I may have or which hereinafter may accrue to me against The Quanta instructor from and against any liability arising out of or connected in any way with my participation in this class or activity, even though that liability may arise out of negligence or carelessness on the part of the person mentioned above. I understand that accidents and injuries can arise from participation in this class, activity or therapy; knowing the risks, nevertheless, I hereby agree to assume those risks on behalf of myself and to release and to hold harmless all of the persons or entities mentioned above whom (through negligence or carelessness) might otherwise be liable to me (or my heirs or assignees) for damages. It is further understood and agreed that this waiver, release and assumption of risks has been freely entered into and is to be binding on my heirs and assigns.

By my signature below, I acknowledge that I have read this document and understand its contents.

Check the appropriate box(es) and sign: ☐ Participant (over 18) ☐ Parent ☐ Legal Guardian

Participant Signature:_____

Print Name: _____

Date: _____