Shalogapé Wellness Care

Quantum Scanner and NLS Evaluation Form

Personal Details

Name And Surname_____

Phone _____ Cell Phone _____

Birthdate _____ Height _____ Weight _____

Blood Type _____ E-Mail Address _____

Analysing Stress In Body

Please List Any Organs Removed _____

_____

Please Indicate Any Chronic Condition Currently Being Treated For:

Condition	Mark with X (only where applicable)
Heart Condition	
Diabetes	
Hypertension / Hypotension	
Arterial Disease	
Endocrine Condition	
Pregnant currently	
Implants	
Pacemaker	
Epilepsy	
Menopause	
Thyroid	
Asthma	
Auto Immune Disorders	
Rheumatism	
Arthritis	
Urological Condition	
Neurological Condition	
Gastrointestinal Condition	
Tuberculosis	
Organ Transplant	

Condition	Mark with X (only where applicable)
Toxin Exposure	
Skin Conditions	
Glaucoma	
Pregnancy	
Menstruation	
Smoker	
Alcohol user	
Dental fillings	
Circulatory disease	
Cold extremities	
Artery or vein problems	
Addictions	
Toxic exposure	
Allergy tendency	
Congenital disorder	
Endocrine disturbance	
Hormonal problems	
Glandular problems	
Regulatory problems	
Emotional problems	
Eating disorders	
Recent weight gain or loss	

Other of importance that was not mentioned above:

_____

_____

_____

Please List Any Areas Of Concern

_____

_____

List any inherited disorders

_____

_____

Please indicate the following:

Personal stress levels	Low	Med	High	Very High
Number of sugar products per day	3	4	5	More
Number of exercise sessions per week (at least 25 min)	None	1 - 2	3	More
Average alcoholic drinks per day				
Number of cups of coffee, tea or caffeine products (incl. chocolate) per day				
Number of water or natural fruit juice drinks per day				

WELLNESS & BIO-FEEDBACK RESEARCH AND TRAINING CONSULTATION WAIVER

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.

- I fully understand the difference between the practice of allopathic (conventional) medicine, and a nutritional wellness consulting and Bio-Feedback
- I fully understand that the services provided by the attending technician are not allopathic/Medical, but are strictly behavioural, stress or Bio-Feedback in nature.
- Any reference to patient within this Frequency balancing is solely due to the technical terminology within the Quantum and NLS program and in no way implies that the client is a medical patient.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.

- 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 the medical aid companies may not accept this treatment for a claim or payment.
- I understand that payment is expected at the time of service.
- 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 a scheduled appointment I will be charged full rate for that time.
- 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.
- The Food and Drug Administration have not evaluated these statements. This product is not intended to diagnose, treat, cure or prevent any disease.
- I understand the Wellness Centre does not guarantee satisfactory or successful results of any kind.
- Myself, my spouse, my children or any other dependant or representative, will claim nothing in case of any loss or damage resulting from any bodily injuries, loss of life or loss of or damage to property, caused by or arising out of, or which is in any way connected with our voluntary participation in activities at or treatment by Shalogapé Wellness Care or any person in their employ.
- I have chosen to attend for a scan and/or therapy at Shalogapé Wellness Care under no duress, and agree to be treated under their supervision.
- I have made myself familiar with the rules, important information and declaration outlined by the Centre and agrees.
- I agree that I have completed the above form and health questionnaire truthfully and honestly.

Signature _____ Date _____

Operator _____

VERY IMPORTANT: How / Where / From whom did you hear about our company?

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