



Contact Information

Date: _____

Mr., Mrs., Ms., Dr., Other _____

First Name: _____ Last Name: _____

Address: _____

City, Province: _____ Postal Code: _____

Home Tel.:(____) _____ Bus. Tel.: (____) _____ Cell. Tel.: (____) _____

E-mail Address: _____

Date of Birth (D/M/Y) _____ Age: _____

Occupation (Yours): _____

Emergency contact: _____ Phone Number: _____

How did you hear about our office?

One of our clients told you about us ___Friend ___ Phone Book ___ Sign ___ Website ___Other ___

Best time for our consultants to reach you? _____

Best way for our consultants to communicate with you? E-mail _____ Phone _____ Both: _____

E-mail address or phone number you would like us to communicate with you if different than above: _____

Please take the time to answer the following questions. It will help us help you better.

A. What are the 3 Major Concerns for you to be consulting our company?

1. _____
2. _____
3. _____

B. What do you think are the 3 biggest obstacles for you to resolve these 3 major concerns?

1. _____
2. _____
3. _____

C. When and Where do you think these concerns first presented themselves?

1. _____
2. _____
3. _____

D. Write down 3 things that make these concerns worse/difficult to achieve?

1. _____
2. _____
3. _____

E. Write 3 major problems/negative feelings caused by these concerns?

1. _____
2. _____
3. _____

F. How dedicated are you to resolve these concerns?

Poorly dedicated Somewhat dedicated Very dedicated

G. Write down 5 things that you have done to deal with these concerns and how effective they were.

Things Done	Not effective <input type="checkbox"/>	Effective <input type="checkbox"/>	Very effective <input type="checkbox"/>
1.			
2.			
3.			
4.			
5.			

H. To what percentage are you achieving what you want to achieve in your life?

0 - 25 % 26 - 50 % 51 - 75 % 76 - 100 %

I. Are you aware of any self-defeating patterns?

Not aware Somewhat aware Very aware

J. Do you sense that your life has a purpose?

No sense of purpose

I have somewhat a sense of purpose

I know exactly what my purpose is

K. What do you like to do that brings your great joy? How often do you do it during the week?

What you like to do that brings you great joy	Frequency during the week
1.	
2.	
3.	

Thank you for taking the time to answer this questionnaire.

K. Please read and sign:

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my relationship with Awakening Potentials Inc. any outstanding balance on my account is due immediately. I further understand that the services provided by the consultants of Awakening Potentials are provided under coaching/consulting or training headings and are not covered by any insurance company but if I own my own business my coaching/consulting or training from Awakening Potentials might be considered as an expense.

We also ask that you please **do not wear perfume or cologne when coming into our office.** We consult clients who have severe allergic reactions to these products. Thank you so much for your co-operation.

Signature: _____

Today's Date: _____

Attention: When your concerns are demonstrating themselves through symptoms in your body please kindly continue with the questionnaire.

1. Have you ever had any of the following?

Aneurysm __ osteoporosis __ diabetes __ arthritis __ S.T.D. __ respiratory conditions __
epilepsy __ cancer __ strokes __ allergies __ heart conditions __ hepatitis __ overstress __
fatigue __ polio __ sleeping difficulty __ pneumonia __ pleurisy __ asthma __ psoriasis __
HIV __ sinus conditions __ eating disorder __

2. Childhood conditions you had, please indicate:

Measles __ mumps __ chicken pox __ whooping cough __ scarlet fever __ diphtheria __
rheumatic fever __ typhoid fever __ ear infections __ tubes in ears __ chronic ill __

3. Are you currently under medical care? Yes No

If yes please explain: _____

LIFESTYLE HISTORY

When was your last visit to the dentist? _____

Purpose of the dental appointment: _____

Do you smoke: Yes No

Rate your appetite: Poor Fair Medium Good Excellent

Rate your diet: Poor Fair Medium Good Excellent

Do you eat regularly: Breakfast Lunch Dinner

Do you eat per day: 1 meal 2 meals 3 meals 4 meals more than 4 meals

Fall and Accidents - list: _____

Have you ever been knocked unconscious: Yes __ No __ Don't know __

If yes, for how long: _____

Have you previously been hospitalized: Yes __ No __

Please list: _____

Past History Form

Please check the appropriate circle for any of the following symptoms that you have or have had previously.

O = Occasional F = Frequent C = Constant

O F C

0 0 0 allergy
0 0 0 chills
0 0 0 convulsions
0 0 0 dizziness
0 0 0 fainting
0 0 0 fevers
0 0 0 headaches
0 0 0 loss of sleep
0 0 0 nervousness
0 0 0 depression
0 0 0 neuralgia
0 0 0 numbness
0 0 0 sweats
0 0 0 loss of weight
0 0 0 tremors

MUSCLE & JOINT

0 0 0 arthritis
0 0 0 bursitis
0 0 0 foot trouble
0 0 0 hernia
0 0 0 low back pain
0 0 0 neck pain
0 0 0 neck stiffness
0 0 0 pain between shoulders

RESPIRATORY

0 0 0 chest pain
0 0 0 chronic cough
0 0 0 difficulty breathing
0 0 0 spitting blood
0 0 0 throat phlegm
0 0 0 wheezing

EYES, EARS, NOSE & THROAT

0 0 0 colds
0 0 0 crossed eyes
0 0 0 deafness
0 0 0 dental decay
0 0 0 asthma
0 0 0 ear aches
0 0 0 ear discharges
0 0 0 ear noises

O F C

0 0 0 sinus infections
0 0 0 enlarged glands
0 0 0 enlarged thyroid
0 0 0 sore throats
0 0 0 tonsillitis
0 0 0 eye pain
0 0 0 failing vision
0 0 0 far sighted
0 0 0 gum trouble
0 0 0 hoarseness
0 0 0 nasal obstruction
0 0 0 near sighted
0 0 0 nosebleeds

CARDIO-VASCULAR

0 0 0 rapid heart beats
0 0 0 slow heart beats
0 0 0 irregular heart beats
0 0 0 swelling of ankle
0 0 0 hardening of arteries
0 0 0 high blood pressure
0 0 0 pain over heart
0 0 0 poor circulation

GASTRO INTESTINAL

0 0 0 excessive hunger
0 0 0 burping or gas
0 0 0 liver trouble
0 0 0 colitis
0 0 0 colon trouble
0 0 0 constipation
0 0 0 diarrhea
0 0 0 difficult digestion
0 0 0 distension of abdomen
0 0 0 stomach pain
0 0 0 gall bladder trouble
0 0 0 hemorrhoids
0 0 0 intestinal worms
0 0 0 jaundice
0 0 0 poor appetite
0 0 0 nausea
0 0 0 vomiting
0 0 0 vomit blood

O F C

SKIN

0 0 0 boils
0 0 0 bruise easily
0 0 0 dryness
0 0 0 hives or allergy
0 0 0 itching
0 0 0 skin rash
0 0 0 varicose veins

GENITO-URINARY

0 0 0 bed wetting
0 0 0 blood in urine
0 0 0 frequent urination
0 0 0 loss control urine
0 0 0 kidney infection
0 0 0 painful urination
0 0 0 prostate trouble
0 0 0 smell of urine

PAIN OR NUMBNESS IN;

0 0 0 shoulders
0 0 0 arms
0 0 0 hands
0 0 0 hips
0 0 0 legs
0 0 0 knees
0 0 0 ankles
0 0 0 feet
0 0 0 painful tail bone
0 0 0 sciatica
0 0 0 swollen joints

FOR WOMEN ONLY

0 0 0 cramps
0 0 0 heavy flow
0 0 0 light flow
0 0 0 irregular cycle
0 0 0 painful cycle
0 0 0 discharge
0 0 0 sore breasts

Menopausal: yes no

Last menstruation date: _____

Pregnant: yes no

Due date: _____

List any medication or drugs you are currently taking:

List the surgery and operations that were performed on you:

List the surgery that were recommended but not performed:

List all the medical tests that were performed on you within the past 5 years and the results:

Test	Result

List any vitamins and minerals taking currently:

PAIN PROFILE

NAME: _____ DATE: _____

- **PLEASE** Draw a picture of yourself – (don't worry about the art work, just do your best) **This really is important!**
- Draw in your face
- Show area (s) of pain or unusual feeling
- Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Indicate problem areas as follows Numbness :

Pins and Needles: 000000

Burning: xxxxxx

Aching: *****

Stabbing: /////

**Thank you very much for filling up this questionnaire, our next step is to get working together to bring you forward on your path.
To Your Health and Success!**