



Advanced Holistic Medical Healthcare

Life Transformation Technology Program Questionnaire

Please complete before your session

All information that you give on this questionnaire and during any consultation and/or sessions is kept strictly confidential.

CLIENT INFORMATION

First Name _____ Date of Birth _____

Middle _____ Age _____

Last _____

Circle: M F Circle: Mr Miss Mrs Ms.

Circle: Single Married Separated Divorced Widowed

Email _____

Street Address _____

City, State & Zip code _____

Home Phone# _____

Cell Phone# _____

Employer _____

Employer City, State, Zip _____

Work Phone# _____

Who Referred you to the Chari Center? _____

EMERGENCY CONTACT INFORMATION

Name of Local Friend or Relative (not living at same address) _____

Relationship to Client: _____

Best Phone No. _____

Address, City, State: _____

DISCLAIMER PLEASE NOTE:

Dr. Chari is NOT a primary healthcare physician. Please consult your primary care physician for your annual physical exam, prescription refills & emergency medical needs. Please sign below to indicate that you understand these terms, and consult Dr. Chari, Deepak Chari and the Chari Center at your own risk/responsibility.

Name: _____ Date: _____



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Life Transformation Technology Program Questionnaire

Name: Date: Age: Sex:

Please answer the questions below:

Are you currently under the care of a psychiatrist? Yes No

If yes, what condition(s) are you receiving treatment for? Also, what medications have been prescribed by your psychiatrist (dosage, times per day and how long you have been on the medication(s)? Use additional paper if necessary.

Do you have a Pacemaker? Yes No

Do you have an implantable defibrillator? Yes No

History of Seizures/Epilepsy? Yes No

History of Bi-Polar Disorder? Yes No

Are you currently being treated with Lithium? Yes No

Are you currently being treated with Dilantin, Phenobarbital or other anti-seizure medications? Yes No

Do you have a history of suicide attempts? Yes No

If yes, when did this occur? (Please provide more details and use additional paper.)

Do you have any history of brain tumors? Yes No

If yes, when? _____

Do you have a history of high blood pressure? Yes No

Do you have a history of a heart attack? Yes No

Have you had angioplasty, stents or bypass Surgery? Yes No

Do you have a history of a stroke? Yes No

Are you on the medications Coumadin or Plavix? Yes No

Do you have a history of migraine headaches? Yes No

Do you have a history of hypo- or hyperthyroidism? Yes No

Are you sensitive to bright lights or sounds? Yes No

If you're a woman, are you currently pregnant? Yes No



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1. **What are you looking to achieve with us?**

2. **What are 3 top issues that are currently stressing you in your life?**
(Ex. Business, work, relationships)
 - **Please rank your current concerns and rate their severity (on a scale of 1-10; 10 being the most severe).**

4. **What treatment(s) have you received to help you resolve the stress? (counseling, therapy, biofeedback, hypnosis, etc.)**

5. **Medications: Please list any prescription and non-prescription (over the counter) medications you are currently taking. Include birth control pills, aspirin, any kind of pain medication, antacids, etc.**
 - **Drugs you are on? Give the dosage (milligrams) & # of times per day.**
 - **How long have you taken each medication (days/weeks/months/years)?**
 - **Why are you on each of the Medications?**



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6. **What supplements are you using to relieve stress and anxiety?**

7. **Circle if you have a history of any of the following:**

High Blood Pressure

Thyroid conditions (hypo or hyperthyroid)

Diabetes

Asthma

Arthritis

Cancer

Type

Year Diagnosed

Treatment received

8. **Past Medical History (previously diagnosed illnesses/treatment/hospitalization)**

Conditions not listed in #7.

10. **How is your digestion? Highlight whatever applies...**

Adequate

Poor

Acid Reflux

Burping often

Bloating

Heartburn

Stomach

Gas

11. **How is your sleep (circle)?**

Restlessness

Hard to get to sleep

Wake up often

Wake up tired

Other sleep complaints:

12. **Who is your primary care physician?**

Name:

Phone:



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13. Do you consult any specialists? Please list:

14. For Women only: Are you pregnant ? (Y/N): _____

16. Occupation: _____

17. Are you currently addicted to any of the following (circle)? (kept confidential)

- | | | |
|--------------|--------------------|-------------------------|
| Cigarettes | Alcohol | Recreational Drugs |
| Pain-killers | Prescription drugs | Food / sugar/ chocolate |
| Cocaine | Crystal meth | Marijuana |
| Heroin | | Other? |

If so, what counseling and/or treatments did you receive?

18. Have you attended AA and/or other Support Groups?

19. Do you currently smoke?

If so, how much/often do you smoke?

What age did you start?

How long have you smoked?

What do you smoke – cigarettes, cigars, pipe, marijuana, etc.?

When do you smoke? Socially, alone, after meals, etc.

If you still smoke, have you tried quitting in the past?

If you no longer smoke, when did you quit?

What motivated you to quit smoking?

How did you quit smoking? (e.g., hypnosis, medications)



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19. Do you currently drink alcohol?

If yes, how much and how often?

What age did you start drinking alcohol?

For how long have you been drinking alcohol?

What type of alcohol do you consume – beer, wine, spirits, etc.?

How much do you typically drink at a time?

When do you drink – socially, alone, with meals?

If you still drink, have you tried quitting in the past?

If you no longer drink alcohol, when did you quit?

What motivated you to quit drinking?

How did you quit drinking?

20. Do you currently use any recreational drugs (inc. oral, inhaled, intravenous)?

If yes, which type of drugs do you use?

How often? (times per week, day, or month)

When did you start using drugs?

For how long have you used drugs?

Have you tried quitting in the past?

If you no longer take drugs, when did you quit?

What motivated you to quit taking drugs?

How did you quit using drugs? (through hypnosis, medication, etc.)?

21. Parents and Upbringing

Please describe the personalities of both of your parents and/or step-parents.

Also describe how your parents treated each other while you were growing up. If your parents divorced, why did they divorce and how old were you when they divorced? (Use additional paper if necessary.)

Mother:

Father:

Stepmother:

Stepfather:



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- 22. Describe your childhood and what it was like growing up in your household with your parents, siblings and other significant relatives (who had an impact on your life. Were they loving & close, supportive, distant, abusive, traumatic, fearful, estranged, other? In addition, which parent(s) or siblings are you closest to?**

Childhood conditions:

Siblings or other relatives

- 22. Describe the personalities of your current spouse/partner, and ex-spouses/partners:**

Current:

Significant Ex:

Significant Ex:

- 23. Describe your relationship with your current spouse and significant previous relationships (e.g., loving, supportive, abusive, traumatic, other?):**

Current:

Significant Ex:

Significant Ex:



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- 28. What events have significantly impacted your life? (ex. divorce, illness, death of a loved one, accident/injury, serious health issue, or problems with your career or business)? When did those events occur?**



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INFORMED CONSENT

Patient Name: _____ Date: _____

I UNDERSTAND THE FOLLOWING:

1. I understand Mr. Deepak Chari is a Certified Biofeedback Specialist. He is qualified to help me identify the causes of my stress, enhancing the quality of my life and improve my peak performance.
2. I understand that I am responsible for my health and well being; and I am interested in taking care of my body, resolving my emotional issues, reducing my stress and enhancing the quality of my life.
3. I further understand alternative healing is not a substitute for adequate medical care and I intend to remain under the care of my primary healthcare provider.
4. I understand certain services provided by Dr. Roopa Chari and Mr. Deepak Chari are contraindicated for women during pregnancy, people with a pacemaker, implantable defibrillator or insulin pump, people with certain allergies and people with certain medical and psychiatric conditions. I also understand all healing may cause me some minor discomfort in the form of aches and pains, headaches, emotional release or increased emotionality. If I have any concerns about these things, I will keep Dr. Roopa Chari and Mr. Deepak Chari fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.
5. I understand Mr. Deepak Chari will keep all information they learn about me completely confidential unless I release them in writing or as specifically required by law. I further understand Mr. Chari will not discuss anything with me publicly unless I initiate the conversation and the topics of discussion.
6. I have disclosed all prescription and over the counter medications, supplements, vitamins, minerals, enzymes, herbal remedies and/or other remedies I am currently taking.
7. I have disclosed other therapies, such as medical, chiropractic, acupuncture, homeopathic, or other treatments that I am currently undertaking.
8. I understand that the recommendations given by Dr. Chari are not intended as substitute for conventional medical care.
9. I further understand that Mr. Deepak Chari and the Chari Center of Health, Inc. does not make any claims medical, or otherwise or any guarantees on their work and in return services all clients to the best of their ability.
10. I further understand that sessions with Deepak Chari & the Zyto Evox involve possibilities of unsuccessful results from both known and unknown causes.
11. I understand that Mr. Deepak Chari will discuss his fees with me prior to any sessions with the Zyto Evox program.



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12. I understand that all fees are due and payable in full. I understand the Chari Center of Health charges a fee for all services which is payable by cash, credit cards (Master Card, VISA, Discover), debit cards, money order or check at the time services are delivered. In the event my check is not honored by my bank, I agree to pay an additional fee of \$35.00 for this inconvenience. The charges for the consultations and sessions are subject to change.
13. I understand that the Chari Center of Health, Inc. does not accept insurance as payment for services nor does it submit claims to insurance carriers. Patients will be given receipts upon payment of services rendered. The Chari Center of Health does not participate in any insurance programs, whether government and private.
14. I understand that the Zyto EVOX, Zyto Balance & AmpCoil technologies, the mind/body techniques, ancient healing techniques, natural remedies, supplements, herbal remedies, natural health programs and detoxification programs are not intended to diagnose, treat or cure any medical condition.

“Except in the case of gross negligence or malpractice, I or my representative(s) agree to full release and hold harmless Dr. Roopa Chari, Deepak Chari & The Chari Center of Health from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).”

By signing below, I acknowledge that I have read and understand this form. I agree to allow Mr. Deepak Chari and any other qualified employees of the Chari Center of Health to provide the natural healing services, techniques and modalities I agree to receive.

Patient Name

Patient Signature

Date:

Physician/Practitioner Signature

Date



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DIRECTIONS TO THE CHARI CENTER

Coming from South of Encinitas, CA

- Take I-5 N/San Diego Fwy N toward Los Angeles
- Take the Manchester Ave exit, (EXIT 39)
- Turn left onto Manchester Ave (this will turn into El Camino Real)
- Turn right onto Manchester Ave
- **4401 MANCHESTER AVE is on the left side (Landmark is our building is next to Rite Aid and on the driveway is a sign that says "Office Condomiums")**

* When you come into the driveway, our building #4401 is the first building on the left hand side. We are in the back of this building.

* To park, go to the second driveway on the left and make a left turn and park in the back of the building. Walk down the ramp and take the elevator to the second floor. Make a left out of the elevator and walk towards the back balcony and turn right. Our Suite is #201 (next to Accupuncture4U).

Coming from North of Encinitas, CA

- Merge onto I-5 S/San Diego Fwy S toward San Diego.
- Take the Encinitas Blvd exit (EXIT 42) towards Encinitas.
- Turn left onto County Hwy-S9/Encinitas Blvd.
- Turn right onto Manchester Ave.
- **4401 MANCHESTER AVE is on the right side. (Landmark is our building is next to Rite Aid and on the driveway is a sign that says "Office Condomiums")**

* When you come into the driveway, our building (4401) is the first building on the left hand side. We are in the back of this building.

* To park, go to the second driveway on the left and make a left turn and park in the back of the building. Walk down the ramp and take the elevator to the second floor. Make a left out of the elevator and walk towards the back balcony and turn right. Our Suite is #201 (next to Accupuncture4U).