



*Center For
Energy Healing*
Creating a Balance Within

(908) 249-1061
centerforenergyhealingnj@gmail.com
www.centerforenergyhealing.com

ANF Consent Form

I, _____ (client) give my consent for an Amino Neuro Frequency (ANF) treatment by my practitioner, Lori Prior. I understand that ANF is a non-invasive frequency based therapy that involves the application of wearable carbonized metal discs. These skin applied, non transdermal devices are activated by body heat to target pain and inflammation without the use of drugs or chemicals.

It's been explained to me that ANF is a specialized, complementary/alternative treatment that assists the body in the normalization and optimization of many conditions at the cellular level.

I have been made aware that there may be some side effects post treatment as my body adjusts to the new signals from the discs. These temporary mild "detox" symptoms are a good indication that the discs are working to normalize the affected area(s) however the discs are working whether or not detox symptoms are felt. Some of the symptoms may include but are not limited to fatigue, headache, dry mouth and dizziness. Drinking additional water will minimize any discomfort.

I also understand that although ANF Therapy supports recovery, mobility, pain reduction and physiological balance, it is not intended to replace standard medical care for any specific condition(s). ANF may be used as a stand alone therapy for a variety of issues or health maintenance. This therapy may also be used in conjunction with a current medical treatment plan as it naturally supports the body's innate healing ability.

I agree to keep my practitioner informed of any health or medication changes other than what was listed on the intake form. I understand the importance of following the practitioner's instructions to obtain the best results. Although consistency is recommended to relieve/lessen symptoms, I am free to cancel treatment at any time.

By signing below I acknowledge that I have read, understand and agree to begin treatment with this modality. Parent must sign if client is a minor.

Client Signature: _____

Date: ____ / ____ / ____



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Client Intake Form

Date ____/____/____

Name: _____

Date of Birth: _____

Address: _____

Phone: (Home) _____ (Mobile) _____

Emergency Contact: _____ Relation: _____

Phone: (Home) _____ (Mobile) _____

Primary Care Physician: _____ ☐ Consent to Contact Physician Phone: _____

To Be Filled Out By Practitioner

SPO2: _____ / _____

Blood Pressure: _____

Pulse: _____

What can we help you with today? _____

Are you experiencing pain? ☐ Yes ☐ No If yes, please explain where and for how long: _____

Please share a little about yourself. What do you do for a living? If retired, what type of work did you do? _____

On a scale of 1-10, what is your stress level on most days? _____ What do you do to manage stress? _____

Please describe yourself emotionally? _____

How many hours of sleep do you get every night? _____ How do you feel when you wake up? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often and what type? _____

Do you smoke? ☐ Cigarettes ☐ Marijuana If yes, how much? _____

Do you exercise? ☐ Yes ☐ No If yes, what do you do and how often? _____

Do you take vitamins/supplements? _____

Do you skip meals? _____

Do you have any allergies? If yes, please list: _____

Do you experience small memory losses? ☐ Yes ☐ No

Did you suffer any trauma before the age of 10? ☐ Yes ☐ No If yes, please explain: _____

Have you been a car accident? _____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, are you still receiving treatment? _____

Have you ever had surgery? ☐ Yes ☐ No If yes, please explain what type? _____

Have you tried other methods of alternative therapy? ☐ Energy Work ☐ Meditation/Guided Imagery ☐ Acupuncture ☐ Massage

☐ Other: _____

**ANF Requires a follow-up appointment three (3-4) days after the first treatment to reassess.
We recommend routine appointments thereafter to monitor progress.**

Continued on back



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Client Intake Form (continued)

These discs do not contain medicine and therefore will not interfere with any current treatment, aside from chemotherapy or radiation. There are no side effects aside from possible detoxification symptoms which include tiredness, lack of energy, headache, dry mouth, lightheadedness, dizziness, mild flu symptoms, runny nose, skin conditions, and general malaise. The client will be made aware of these possible symptoms, which are a result from the treatment and will be advised to drink more water in order to lessen them.

- I understand and consent to this treatment for my specific condition(s). I undertake this therapy willingly and agree to follow my practitioner's advise in order to restore healthy bodily function.
- I understand that adequate water intake is essential to this therapy and I agree to follow my practitioner's recommendations to obtain optimal benefits.
- Furthermore, I understand that I will begin this treatment of my own free will and can stop at any time without explanation. I realize that should I choose to terminate therapy prior to the normalization of my physical dysfunction(s), my symptoms or conditions may return.
- **Medical Disclaimer:** I will keep my therapist informed about any changes in my health.

☐ I have filled out this questionnaire to the best of my ability.

☐ Print Client Name: _____ ☐ Print Guardian Name: _____

Authorized Signature ☐ Client ☐ Guardian: _____ Date: _____

An Authorized Signature from a Parent/Guardian is required for anyone under the age of 18.

The information/services provided in wiriting or on the website is intended for educational purposes only and should not be considered a substitute for professional medical advice, dx, or treatment. Results are individual. Specific outcomes are not guaranteed.



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Health History

Date ____ / ____ / ____

Please check the following conditions that apply to you, whether past or present.

Musculoskeletal

- | | | |
|--|--|--|
| ☐ Headaches | ☐ Shoulder /neck pain | ☐ Bursitis |
| ☐ Joint stiffness | ☐ Arm/ hand pain | ☐ Osteoarthritis |
| ☐ Spasms/ cramps | ☐ Leg/foot pain | ☐ Rheumatoid arthritis |
| ☐ Broken bones | ☐ Chest/ abdominal pain | ☐ Scoliosis |
| ☐ Sprains | ☐ Jaw pain/TMJ | ☐ Bone or joint disease |
| ☐ Back/ hip pain | ☐ Tendinitis | ☐ Trouble walking |

Circulatory and Respiratory

- | | | |
|--|--|---|
| ☐ Dizziness | ☐ Heart failure | ☐ Low blood pressure |
| ☐ Shortness of breath | ☐ Heart attack | ☐ Varicose veins |
| ☐ COPD | ☐ Sinus issues | ☐ Lymphedema |
| ☐ Fainting | ☐ Asthma | |
| ☐ Cold hands/ feet | ☐ Seasonal allergies | |
| ☐ Swollen ankles | ☐ High blood pressure | |
| ☐ Blood clots | | |

Skin

- | | | |
|---|---------------------------------|---|
| ☐ Rashes | ☐ Ulcers | ☐ Acne |
| ☐ Allergies | ☐ Warts | ☐ Cosmetic surgery |
| ☐ Fungal infection | ☐ Moles | ☐ Chemical sensitivity |

Digestive

- | | | |
|--|---|---|
| ☐ Nervous stomach | ☐ Fecal incontinence | ☐ Crohn's disease |
| ☐ Loss of appetite | ☐ Urinary incontinence | ☐ Colitis |
| ☐ Hiatal hernia | ☐ Diverticulitis | ☐ Ulcers |
| ☐ Constipation | ☐ Irritable bowel | ☐ Urinary tract infections |
| ☐ Diarrhea syndrome | ☐ Ostomy devices | |

Reproductive System

- | | | |
|--|---|--|
| ☐ Current pregnancy | ☐ Endometriosis | ☐ Impotence |
| ☐ Menopause | ☐ Hysterectomy | ☐ Hormone replacement |
| ☐ Pelvic inflammatory disease | ☐ Benign prostatic hypertrophy | |

Nervous system

- | | | |
|---|--|--|
| ☐ Numbness/ tingling | ☐ Fibromyalgia | ☐ Herpes/ shingles |
| ☐ Migraines | ☐ Paralysis | ☐ Benign tremor |
| ☐ Chronic pain | ☐ Epilepsy | ☐ Cerebral palsy |
| ☐ Stroke | ☐ MS/MD /Parkinsons | ☐ Brain/ spine injury |

Other

- | | | |
|--|---------------------------------------|--|
| ☐ Forgetfulness | ☐ Diabetes | ☐ Infectious diseases |
| ☐ Depression | ☐ Fibromyalgia | ☐ Liver disease |
| ☐ Trouble concentrating | ☐ Post-polio | ☐ AIDS/ HIV+ |
| ☐ Hearing impaired | ☐ Cancer | ☐ Kidney disease |
| ☐ Visually impaired | ☐ Hepatitis C | Other: _____ |