



After appointments have been scheduled and confirmed, we recommend the following:

1. Plan to dress comfortably when visiting the Life Vessel Center.

Remember that at certain times of year, it can be very cold in Colorado. Choose your clothing accordingly. We also ask you to refrain from wearing any perfumes or colognes. All metal, including jewelry must be removed for the treatment. Pacemakers and implanted metal are permissible. No other attachments are allowed into the vessel.

The vessels are large and roomy. Although there is light and sound frequency, it is not enough light for reading. We suggest you be prepared to lie in the vessel for the hour and relax. It doesn't matter whether a person sleeps, and it doesn't matter if the eyes are open or closed. It's easy to get into and out of the vessel and although the front doors close, a simple push and they completely open up.

2. Use the days you are here to relax and heal. Long walks and hiking, shopping and visiting local tourist attractions are discouraged. Prepare to give yourself the gift of health. Your health is the most important thing you have. It should be your priority in life above everything else. Your health allows your joy, love, productivity and creativity to flourish.

3. Should you plan more than one visit to the Life Vessel? Everyone is different, thus the number of sessions is dependent on the individual. An initial interview will be conducted to determine a protocol specifically for each client. The average number of sessions per client is eight to twelve and sessions of 4 are recommended every 21-25 days for best results. Factors that can be controlled by the individual which would aid the healing process are: drinking the required water, eating a good diet and staying away from stimulants such as coffee, tea and nicotine, eliminating the use of alcohol or drugs, avoiding emotional, environmental or physical trauma, getting enough rest and the *big one*...try to avoid STRESS. Factors inherent to the individual's disorder that would increase the number of sessions required are: genetic defects, neurological, bone or muscle damage, chronic viral, bacterial or fungal disease, chronic illness and other disease.

Once you start Life Vessel treatments and through 21 days following we can't stress enough that you avoid heavy foods / meals (pastas, breads, cream sauces, greasy or fried foods, etc), drink your water, avoid caffeine, alcohol, strenuous exercise, too much stress, too much sugar...basically use your best judgment for a healthy lifestyle and diet.



4. **On the first scheduled appointment day**, arrive 30 minutes early with completed paperwork for your intake and ANSAR test (if you opted to add that to your pre- and post-treatments for an additional cost). The Life Vessel session takes one hour +. Plan on about a two-hour stay the first day (days 2 and 3 you need only come at the appointment time and plan for 1 hour and 30 minutes for the appointments) We run on-time and rarely do people have to wait over just a few minutes. We do not over-schedule but plan more than enough time for each individual.

5. **Please reschedule any chiropractic**, massage, acupuncture, biofeedback, or any other energy work. These appointments need to be a minimum of 21 days after your last Life Vessel appointment or 3-5 days prior to your next appointments. Also, homeopathics are considered an energy therapy that will interact with the Life Vessel energy. It is recommended that all homeopathics be discontinued while under going the Life Vessel sessions.

6. **Commit to drinking a minimum of one gallon of water a day** once your first Life Vessel session has taken place. This is a requirement and we will be unable to continue sessions unless you are prepared to do so. If you cannot drink the water we can provide an IV for hydration (inquire for details and additional fees).

7. **Complete all forms and bring them with you to your first visit.**

8. **Cancellation Policy requires 48 hours notification** or payment for one-half of sessions will be required.

X _____

By signing this form, you the client, are agreeing to all the above.



CONFIDENTIAL CLIENT APPLICATION

Client: _____ DOB: _____ Height: _____ Weight: _____
 Telephone Home: _____ Work: _____ Cell: _____
 Address: _____ Email: _____
 City: _____ State: _____ Zip Code: _____
 Emergency Contact: _____ Relation: _____ Phone: _____
 Relationship Status: Single Married Partner Separated Divorced Widow Widower
 Spouse/Partner Name: _____ # of children _____
 Occupation: _____ Do you enjoy your job? Y N
 Primary Reason for seeing us: _____
 Health Concerns: _____
 Health Goals: _____
 What are your expectations: _____
 Who can we thank for your being here (who referred you): _____

Check conditions listed below which you have experienced: Use P for over a year ago, C for current

METABOLISM

- Weight Gain
- Weight Loss
- High/Low BP
- blood sugar
- thyroid

SKIN

- Rash
- Change in Mole
- Dry Skin
- Acne
- Recent Botox
- Any recent substance Injection under skin

EYES/EARS/MOUTH

- Headaches
- Dizziness
- Ringing in Ears
- Blurred Vision
- Sinus Problems
- Difficulty Swallowing
- Mouth Sores

DENTAL

- Tooth Problems
- Root Canals
- Amalgam Fillings
- Difficulty chewing

CHEST

- Chest Pain
- Palpitations
- Cough
- Shortness of Breath
- Asthma

NEUROLOGIC

- Numbness or Tingling
- Weakness
- Insomnia
- Poor Balance

DIGESTION

- Heartburn
- Abdominal Pain
- Gas/Bloating
- Diarrhea
- Constipation
- Blood in stool
- History of Ulcers
- Colitis
- Liver Disease

URINARY

- Frequent Urination
- Difficulty starting Urination
- Urinary Incontinence

ALLERGIES

- Medications
- Chemicals
- Foods
- Plants

FEMALE

- Pregnant
- Problems with periods
- Excessive Bleeding
- Breast Tenderness
- Breast Implants
- Menopausal Symptoms

STRUCTURAL

- Arthritis
- Bursitis
- Osteoporosis
- Foot/Ankle Swelling
- Blood Clots/Phlebitis
- Varicose Veins
- Recent Surgery
- Neck Pain/Problems
- Back Pain/Problems
- Sciatica

IMMUNE

- Chronic Fatigue
- Fibromyalgia
- Yeast Infections
- Arthritis



Describe any specific medical attention or assistance you will need while visiting our center. _____

Will you be bringing a caregiver, nurse or spouse with you? _____

Please circle the word that best describes your current state of health:

Excellent Good Average Improving Declining Serious Debilitated

What brings you joy? _____

Please circle the most emotional draining relationship or relationship in your life:

Significant Other Job Children Your Relationship with Yourself State of the World

Is your home environment peaceful or stressful most of the time? _____

Do you have trouble concentrating, or 'brain fog'? Y N Do you feel supported? Y N

What drives you, inspires you, gives you a sense of purpose: _____

Please check the emotions that best reflect how you feel most of the time:

<input type="checkbox"/> Joy	<input type="checkbox"/> Sad	<input type="checkbox"/> Excited	<input type="checkbox"/> Optimistic
<input type="checkbox"/> Anger	<input type="checkbox"/> Depressed	<input type="checkbox"/> Passionate	<input type="checkbox"/> Terrified
<input type="checkbox"/> Resentment	<input type="checkbox"/> Hopeless	<input type="checkbox"/> Safe	<input type="checkbox"/> Anxious
<input type="checkbox"/> Peaceful	<input type="checkbox"/> Despair	<input type="checkbox"/> Calm	<input type="checkbox"/> Alone
<input type="checkbox"/> Happy	<input type="checkbox"/> Blissful	<input type="checkbox"/> Afraid	

Do you adhere to any particular diet? _____

Do you drink filtered or purified water? Y N

Describe your exercise/activity routine: _____

Do you have a meditation or relaxation practice? _____

Do you have a strong spiritual belief system? _____

Are you in fear regarding your health? _____

Do you listen to your intuition? Y N

Regaining well being requires a strong personal commitment. How ready are you to make the lifestyle changes, the diet changes and the attitude changes that may be necessary to good health?

Ready Somewhat Not looking to make changes

I have read the above information and have filled out the form to the best of my knowledge. I understand that the questions on this form are being asked in order to better access my current circumstances and their relationship to my well being. I further understand that I am voluntarily agreeing to have a relaxation therapy session in the Life Vessel® and that no medical claims or promises of healing have been given.

Signature: _____ Date: _____



Medications, Herbs, Supplements (list name, dose, and purpose)

We recommend drinking 128 oz (16 cups) of water daily starting on the day before your first Life Vessel session and for the next 21 days. Do you expect any difficulty with this? Y N

Explain: _____

How much do you use? Alcohol _____ Tobacco _____

Coffee/Tea _____ Drugs _____

Injuries/Accidents? Y N When & Describe _____

Traumatic life events leading to any illness: _____

Toxic Exposures: _____

Describe other medical conditions that we should be aware of: _____

__Cancer __Heart Problems __Stroke __Seizures __Diabetes __MS

Other: _____

Areas in body of complaint or tension: _____

Surgeries with dates (include location of metal plates/rods/screws) _____

Family medical history: __Diabetes __Heart Problems __High BP __Cancer __Alzheimer's

Other: _____

Current Pain Level (1=very low, 5=very high): 1 2 3 4 5 Explain: _____

Current Stress Level (1=very low, 5=very high): 1 2 3 4 5 Explain: _____

Current Energy Level (1=very low, 5=very high) 1 2 3 4 5 Explain: _____