***Rayspect.org Individual Trauma & Body Intelligence Assistance   
Application form Q1, 3 hour session, can be split up in 2 sessions or 3 x 1 hour sessions***

***E-mail: info@rayspect.org***

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Profession |  |
| Birth/time  Birth/day  Birth/year |  | Birth/place Birth/Country |  |
| City/Village |  | Country |  |
| E-mail |  | | |

|  |
| --- |
| Who recommended this work to you? |
|  |
| What is your purpose & intention for having this session? |
|  |
| Any dis-ease labels you are dealing with now? |
|  |
| Married – Partners – Living together – Single – Children & Grandchildren ? |
|  |
| First 4 years of life – anything particular? Be specific. |
|  |
| Are you presently taking any medications or drugs? (Name of medication for what condition) |
|  |
| Are you presently using any recreational drugs – alcohol or nicotine? (Amount per day/Week) |
|  |
| Background in education? Job life now? |
|  |
| Any experience with OMAD? Fasting dry or juice? Fruit diet? Plant based/Vegan? Keto? |
|  |
| Food allergies? Any other allergies? |
|  |
| Living in an industrial area or grown up in an industrial area? |
|  |
| Chemical use or environmental, perfumes, soaps, use of cleaning materials at home, pesticides, GMO, Glyphosate, plastic etc.? |
|  |
| WIFI Router? Nearby mobile tower? 5G? Mobile phone? Electricity and/or radiation sensitivity? Home close to power lines? |
|  |
| Lived in a house with mold or live in one with mold now? |
|  |
| Any specific teeth work getting done, having had mouth or cheek issues? Wisdom teeth removed? Are there pieces left? What kind of fillings do you have now? Root Canal work done? |
|  |
| Amalgams, mercury fillings, any removed safely or old fashioned pulling? How many amalgams left? |
|  |
| How do you hydrate? Have a water distiller? Water filter? Hydration knowledge? |
|  |
| What kind of birth did you have? Caesarian? Hospital or at home? Medicine used to provoke birth or instruments to pull you out? |
|  |
| Were you separated from your mother at birth (sent to a nursery)? |
|  |
| Were you breastfed? If yes, how long? |
|  |
| Were you circumcised as an infant? |
|  |
| Please note any interventions shortly after birth such as hospitalization for illness or high jaundice operations – list illnesses as an infant or child. |
|  |
| Did either, or both of your parents lose another child to miscarriage, IVF or Assisted Reproductive Technique, abortion, stillbirth, Sudden Infant Death (SID) (cot death) or childhood death? If yes, are you aware of how this affected you? Please write down dates and details. |
|  |
| Did your parents or grandparents lose a sibling through miscarriage, abortion, still birth or SID (cot death)? Please write down dates and details. |
|  |
| If you ever lost a child to miscarriage, abortion, stillbirth or death please explain circumstances, dates and how this affects you today. |
|  |
| Who raised you? Were your parents your natural parents? Were you raised by a single parent? If your parents split up, how old were you? Did you have other major primary caregivers like grandparents, aunt and uncles, guardians or adoptive parents? |
|  |
| Do you or did you have siblings? What is the following order? State birth year for each one. |
|  |
| Colon issues? Bowel movements? How regular? Easy? Constipation? Diarrhea?  Liver, Eye, Lung, Skin Problems? If skin issues, are you sweating? Bouncing? Skin brushing or Saunas? |
|  |
| Smoker, ex-smoker? Growing up in a smoker home? |
|  |
| Have or had implants? |
|  |
| Any experience with urine therapy? Heard about urine therapy? |
|  |
| Are you vaccinated? Yes/No? Vaccination awareness of ingredients and consequences? Are your children vaccinated? Yes/No? |
|  |
| Exercise, yoga, swimming, bouncing, cycling, walking? What do you do to move or stretch? |
|  |
| Scars from operations or scars from accidents? |
|  |
| Tonsils removed? Gallbladder removed? Thyroid? Anything else? |
|  |
| What type of person do you want to be? |
|  |
| Why is that important to you? |
|  |
| What do you love the most about yourself? |
|  |
| What do you hate the most about yourself? |
|  |
| Do you value living a healthy lifestyle, and what do you value about it? |
|  |
| Why do you want to improve your health habits? |
|  |
| What aspects of being healthy do you care about the most? |
|  |
| Why do you care about them? |
|  |
| Any traumas in youth 0-25 years of age? |
|  |
| Any other traumatic experiences you can share here? Emotional traumas? (Especially early childhood) |
|  |
| Please add any friends, loved ones or colleagues that you are or were emotionally close with, or that had some higher relevance in your life. Someone you loved as a teenager who didn’t love you back. Close friends who left or died. Colleagues who affected your life in a big way. Suicide from someone you knew. Murder, rape case, something that touched you profoundly. |
|  |

I agree to pay within 24 hours before the session. This payment is specified at [www.rayspect.org/services](https://l.facebook.com/l.php?u=http%3A%2F%2Fwww.rayspect.org%2Fservices%3Ffbclid%3DIwAR1D1qFueZbgrospQyOt00HkxTZvM3cWs-CEWRhhDIS8sPcJnr1L_tpPKNk&h=AT1jETmsoZuLxL1D8P-LFFES7415wTEhJijNlOTpIiKDL0_dvVGzciqcmXET6SL4tglZzAJFObbMPy52ls1HwXs8dUJcOVobg1Kaq4ok-e-OOGAouwZFROIxbqVUS4-kL8w6tT1S)

If you do not show up for the session we keep the half-payment unless the session was cancelled within 6 hours before the session.