

Application for BrainSave! Recovery Program



BRAINSAVE!

Your name: _____

Email address: _____

Phone number: _____

Date of Birth: _____

1. Why are you interested in working with Dr. Chiu and applying for the BrainSave! Recovery Program? There are a lot of practitioners out there that specialize in natural medicine. What makes you think Dr. Chiu is the right one for you?
2. Briefly, what are the major post-concussion symptoms that you're still struggling with? How long have you had these symptoms for?
3. What is your biggest frustration with this?
4. What have you tried so far that hasn't worked for you?
5. How much time would you be willing to invest into getting your result?

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:

	5	4	3	2	1
Significantly modify your diet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take nutritional supplements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Modify your lifestyle (i.e. work demands)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Engage in regular brain-training exercises	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Practice relaxation techniques	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have periodic lab tests run to assess your progress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Travel to Berkeley, California for 5-Day Intensive Program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Email/fax completed application to care@helloKoba.com or 773-305-5547