Rife Technology Evaluation - Volunteer Waver

ID# _____

Name _____ Date _____

Address _____ Phone _____

List your Health Status and Brief History here. *(Use other side if necessary)*

_____

_____

_____

(Please feel free to make notes on reverse side)

Please Initial each:

_____ I have seen or attended an introduction to Rife Technology and understand the Rife/Bare technology is experimental and unproven and could be considered dangerous.
_____ No one has clamed this unit will cure or improve anything.
_____ I am asking to use this device and/or be exposed to its effects at my own risk.
_____ I have not been asked for any money or gifts or anything else.
_____ I attend these sessions of my own free will as a volunteer.
_____ No one has solicited my presence.
_____ I have not been promised anything.
_____ I have been advised that if I am under the care of a medical doctor, that I should not be doing this without my doctor's written consent.
_____ I consent to share information pertaining to my use of this device freely with the people of the world.
_____ I will maintain a diary and supply notes for every session I attend or perform.

The effects of the Rife technology are not fully known nor understood.

The following are cautioned NOT TO USE THIS DEVICE:
Those who have:

- Pacemakers
- Auto insulin injection devices
- A person or couples wishing to conceive
- Metal pins, staples, wires or plates *
- Hearing aids *
- Electronic recording devices *
- Anyone pregnant
- Anyone on prescription medication or alcohol or illegal drugs or any combination of same.

My name will not be released as public information without my written consent.

I am prepared to make the following commitment:
I will **ATTEND** for a duration of 6 weeks, twice weekly (currently Mon. & Thur.)
I will **MAINTAIN** a journal describing how I felt prior to joining this program.
I will **HAND IN** every session - the evaluation check off forms
I **DESIGNATE** _____ as my support person. - Phone: _____
I will **PROVIDE** photocopies of any medical test results done for me.

I was introduced to this by (name of person) _____

Signature of volunteer: _____ Date: _____

Signature of witness: _____Date: _____

Special thanks to Don Tuney for making his forms publicly availabl,e and to Jimmie Holman for making these forms distributable and printable in electronic format. Document masters are freely available at ***www.holman.net/rifetechnology***

ID# _____ Name (print) _____ Signature _____
Dates: From _____ to _____ Last session attended _____ This is my _____ (eg. 14th) Session

DAILY REPORT

This is your DAILY REPORT and is best completed at bedtime. Responses are from 0 (none) to 9 (lot)

	M T W T F S S
1. Nausea	|__|__|__|__|__|__|__|
2. Vomiting	|__|__|__|__|__|__|__|
3. Fever	|__|__|__|__|__|__|__|
4. Headache	|__|__|__|__|__|__|__|
5. Chills	|__|__|__|__|__|__|__|
6. Bloating	|__|__|__|__|__|__|__|
8. Flatuient	|__|__|__|__|__|__|__|
9. Fluid retention	|__|__|__|__|__|__|__|
10. Pulse	|__|__|__|__|__|__|__|
regular – erratic – strong – weak	

	M T W T F S S
11. Balance	|__|__|__|__|__|__|__|
12. Walking ability	|__|__|__|__|__|__|__|
13. Strength	|__|__|__|__|__|__|__|
14. Energy level	|__|__|__|__|__|__|__|
15. Endurance	|__|__|__|__|__|__|__|
16. Flexibility	|__|__|__|__|__|__|__|
17. Slept well	|__|__|__|__|__|__|__|
18. Number of Hours	|__|__|__|__|__|__|__|
19. Co-ordination	|__|__|__|__|__|__|__|
19a. Acid Indigestion	|__|__|__|__|__|__|__|

20. **Physical**	M T W T F S S
a. Muscle Pain	|__|__|__|__|__|__|__|
b. Joint Pain	|__|__|__|__|__|__|__|
c. Chest Pain	|__|__|__|__|__|__|__|
d. Back Pain	|__|__|__|__|__|__|__|
e. Internal Pain	|__|__|__|__|__|__|__|
f. Wart/Mole Growth	|__|__|__|__|__|__|__|
g Other _____	|__|__|__|__|__|__|__|

21. **Senses**	M T W T F S S
a. Smell	|__|__|__|__|__|__|__|
b. Vision	|__|__|__|__|__|__|__|
c. Hearing	|__|__|__|__|__|__|__|
d. Touch	|__|__|__|__|__|__|__|
e. Taste	|__|__|__|__|__|__|__|
f. Intuition	|__|__|__|__|__|__|__|
g. Libido	|__|__|__|__|__|__|__|

22. **Cravings** for Sweets/Cigarettes/Alcohol/Prescription Drugs/Other	M T W T F S S |__|__|__|__|__|__|__|

23. **Emotional**	M T W T F S S
a. Angry	|__|__|__|__|__|__|__|
b. Restless	|__|__|__|__|__|__|__|
c. Depressed	|__|__|__|__|__|__|__|
d. Fear	|__|__|__|__|__|__|__|
e. Anxiety	|__|__|__|__|__|__|__|
l. Crying	|__|__|__|__|__|__|__|

	M T W T F S S
f. Dreams	|__|__|__|__|__|__|__|
g. Memory	|__|__|__|__|__|__|__|
h. Focused	|__|__|__|__|__|__|__|
i. Positive Thinking	|__|__|__|__|__|__|__|
j. Stress Level	|__|__|__|__|__|__|__|
k. Other _____	|__|__|__|__|__|__|__|

25. **Signs of Blood** from	M T W T F S S
a. Mouth	|__|__|__|__|__|__|__|
b. Nose	|__|__|__|__|__|__|__|
c. Ear	|__|__|__|__|__|__|__|
d. Hemorrhoid	|__|__|__|__|__|__|__|
e. Stomach	|__|__|__|__|__|__|__|

	M T W T F S S
e. Stomach	|__|__|__|__|__|__|__|
f. Stool	|__|__|__|__|__|__|__|
g. Saliva	|__|__|__|__|__|__|__|
h. Urine	|__|__|__|__|__|__|__|
i. Other _____	|__|__|__|__|__|__|__|

	M T W T F S S
27. Sweating	|__|__|__|__|__|__|__|
28. Ringing in Ears	|__|__|__|__|__|__|__|
29. Rash over Body	|__|__|__|__|__|__|__|
30. Itchiness	|__|__|__|__|__|__|__|
31. PMS	|__|__|__|__|__|__|__|
32. Skin Dryness	|__|__|__|__|__|__|__|
33. Constipation	|__|__|__|__|__|__|__|
34. Diarrhea	|__|__|__|__|__|__|__|
35. Drug Use	|__|__|__|__|__|__|__|
36. Loss of Fillings	|__|__|__|__|__|__|__|

	M T W T F S S
37. Breathing Ease	|__|__|__|__|__|__|__|
38. Floaters in Left Eye	|__|__|__|__|__|__|__|
39. Floaters in Rt. Eye	|__|__|__|__|__|__|__|
40. Urination Ease	|__|__|__|__|__|__|__|
41. Urine "Bubbly"	|__|__|__|__|__|__|__|
42. Appetite	|__|__|__|__|__|__|__|
43. Hair Loss	|__|__|__|__|__|__|__|
44. Coughing	|__|__|__|__|__|__|__|
45. Phlegm colored	|__|__|__|__|__|__|__|
46. Daily Fluids (# of 8oz)	|__|__|__|__|__|__|__|
46a. Swellings _____	|__|__|__|__|__|__|__|

I have *(circle where appropriate)*	M T W T F S S
47. Mouth Sores/Pimples/Cold Sores/Tooth Aches/Foul Taste/Bad Breath	|__|__|__|__|__|__|__|
48. Numbness/Tingling in Body - where? _____	|__|__|__|__|__|__|__|
49. My weight is the same/increased/decreased _____ lbs since _____	|__|__|__|__|__|__|__|
51. a. I feel great emotionally	|__|__|__|__|__|__|__|
b. I feel great physically	|__|__|__|__|__|__|__|

52. Weekly enter the pH level if you do the test! My pH level today is BLUE, RED or None

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Rife Technology Research Sessions

Medical History

(You may complete this form at home and hand it in at the next session)

Name _____

Date _____ ID# _____

Medical History: *(Include all symptoms, treatment, and medications)*

(Please feel free to make notes on reverse side)

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