Health Intake Forms

Patient Name: _____

Date: _____

Address: _____

Date of Birth: _____

City, State, Zip: _____

Phone Number: _____

Gender: ☐ MALE ☐ FEMALE

Email: _____

Marital Status

_____

Primary Care Physician: _____

Referring Physician: _____

Primary Care Physician Phone Number: _____

How did you hear about us? _____

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand.

- We do not treat symptoms or disease;
- An allergy is not a disease, rather a condition;
- A symptom is an attempt by your body to tell you something;
- We will attempt to find the underlining cause;
- We do not use drugs in this program;
- There is no single "healthy" diet that will work for everyone;
- Just because food is considered "healthy", does not mean it is "healthy" for you;
- Your diet consists of everything you **eat, drink, rub on your skin, or inhale**;
- Our procedures are safe and painless.

Briefly describe the reason for your visit and what you hope to accomplish:

_____
_____
_____
_____

WORK ENVIRONMENT:

What is your occupation? _____

Are you exposed to chemicals or strong odors at work? Yes___ No___

If yes, briefly explain: _____

Are your symptoms worse while at work? Yes___ No___

If yes, briefly explain: _____

MEDICATIONS:

PLEASE LIST MEDICATIONS:

CHEMICALS THAT CAUSE SYMPTOMS:

☐ Insecticides & pesticides	☐ Paints &household cleaners	☐ Perfumes & cosmetics
☐ Gasoline & auto exhaust	☐ Stove or furnace emissions	☐ The smell of new fabrics or fabric store
☐ Chemicals in the work place	☐ Laundry detergent	☐ Newsprint

☐Other: _____☐ None

SMOKING:

Do you smoke? Yes____ No____ Number **of cigarettes per day** ____ A **what age did you start?** _____
Does Anyone smoke in your house? Yes____ No____

Did you suffer from any type of physical, chemical or emotional trauma just before your symptoms were first observed?

_____

Have your symptoms ever gone away for any period of time?

_____

FOOD RELATED SYMPTOMS:

- ☐ Symptoms flare 5-60 minutes after meals
- ☐ The smell or odor of some foods increases
- ☐ Some foods cause swelling of the mouth or tongue
- ☐ Some foods cause upset stomach or vomiting
- ☐ Symptoms occur with restaurant salad bars or Asian foods
- ☐ Symptoms occur with any regularly eaten food
- ☐ Preservatives, additives or food coloring increases symptoms
- ☐ Some foods are craved or addictive
- ☐ Some foods cause nasal symptoms
- ☐ Some foods cause rashes or hives
- ☐ Some foods cause diarrhea
- ☐ Some foods cause headaches
- ☐ Some foods cause asthma
- ☐ No problem with foods

FOODS THAT CAUSES SYMPTOM FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE:

☐ Eggs	☐ Milk	☐ Beef	☐ Corn	☐ Wheat	☐ Soybean
☐ Peanut	☐ Pork	☐ Fish	☐ Shellfish	☐ Orange/citrus	☐ Potato
☐ Tomato	☐ Yeast	☐ Chocolate	☐ Coffee/Tea	☐ None	☐ Other

FREQUENCY & SEVERITY OF SYMPTOMS:

- ☐ Constant/Chronic with little change
- ☐ Present part of the time
- ☐ Present most of the time
- ☐ Prevents some with normal life
- ☐ Present rarely normal activities
- ☐ Slight interference
- ☐ Interference with normal life
- ☐ No interference with normal life

VACCINATIONS

Have You Been Vaccinated Against Communicable Diseases? Yes____ No___
Have You experienced and adverse reactions or symptoms after vaccination administered?
Yes____ No____
At What Age were symptoms / reactions experienced? _____

Name of Vaccine: _____

(age in months, years) _____

SYMPTOMS ARE BETTER WHEN:

SYMPTOMS ARE WORSE:

- ☐ Outdoors and better indoors
- ☐ In the bedroom or when in bed
- ☐ During wet or damp weather
- ☐ During known pollen seasons
- ☐ When exposed to tobacco smoke
- ☐ When sweeping or dusting the house
- ☐ In air conditioning
- ☐ Tobacco smoke bothers me more than anything else
- ☐ At nighttime
- ☐ During windy weather
- ☐ When the weather changes
- ☐ In certain rooms or buildings
- ☐ With yard work, cut grass, leaves, hay or barns
- ☐ In areas with mold or mildew
- ☐ In fields or in the country

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU

Digestive Track
- ☐ nausea & vomiting /diarrhea
- ☐ blood and/or mucous in stools
- ☐ constipation
- ☐ bloated feeling
- ☐ stomach pains or cramps
- ☐ heart burn

Ears
- ☐ itchy ears
- ☐ ear aches/ear infections
- ☐ drainage from ear
- ☐ ringing in ears
- ☐ hearing loss
- ☐ reddening of ears

Emotions
- ☐ mood swings
- ☐ anxiety/fear/nervousness
- ☐ anger/irritability/aggressiveness
- ☐ argumentative
- ☐ frustrated/cries easily
- ☐ depression

Eyes
- ☐ watery or itchy eyes
- ☐ red/swollen/itchy eyelids
- ☐ bags or dark circles under eyes
- ☐ blurred or tunnel vision

Heart
- ☐ irregular/skipped heartbeat
- ☐ rapid/pounding heartbeat
- ☐ chest pain

Joints & muscles
- ☐ pain/ache/swollen/tender joints/ muscles
- ☐ arthritis/osteoarthritis
- ☐ stiffness/limited movement
- ☐ feeling weak/tired
- ☐ psoriatic/gouty arthritis

Lungs
- ☐ chest congestion
- ☐ asthma/bronchitis
- ☐ shortness of breath
- ☐ difficult breathing
- ☐ persistent cough
- ☐ wheezing

Mind
- ☐ poor memory
- ☐ difficulty completing projects
- ☐ difficulty with mathematics
- ☐ poor/short attention
- ☐ confusion
- ☐ easily distracted
- ☐ difficulty making decisions
- ☐ learning disabilities

Nose
- ☐ stuffy nose
- ☐ chronically red/inflamed nose
- ☐ sinus problems
- ☐ fever
- ☐ sneezing attacks
- ☐ excessive mucous formation

Skin
- ☐ acne
- ☐ itching
- ☐ hives/rash/dry skin
- ☐ hair loss
- ☐ flushing/hot flashes

Weight
- ☐ binge eating/drinking
- ☐ craving certain foods
- ☐ excessive weight
- ☐ water retention

Genitourinary
- ☐ kidney
- ☐ frequent/urgent urination
- ☐ bladder
- ☐ yeast infections
- ☐ genital/ anal itching/discharge

Mouth & Throat Thrush

- ☐ gagging/clearing throat often
- ☐ sore throat/hoarse voice/voice loss
- ☐ swollen/discolored tongue/lips
- ☐ cancer sores
- ☐ itching on roof of mouth

Head:

- ☐ headaches
- ☐ faintness
- ☐ dizziness
- ☐ insomnia/sleep disorder
- ☐ facial flushing

Other Conditions:

- ☐ Autism
- ☐ A.D.H.D.
- ☐ A.D.D.
- ☐ Psoriasis
- ☐ Eczema
- ☐ Auto Immune Disorder
- ☐ Chronic Fatigue
- ☐ Multiple Chemical Sensitivities
- ☐ Asthma
- ☐ Congestive Heart Failure
- ☐ Sever Diabetes
- ☐ Severe Depression
- ☐ Obsessive Compulsive Disorder

ANIMAL, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE:

☐ Dogs	☐ Cats	☐ Horses or Cattle
☐ Rabbits	☐ Birds or Feathers	☐ Rodents (mice, guinea pigs…)
☐ Bees	☐ None	☐ Other: _____

Symptoms of Hypothyroidism:

- ☐ Fatigue, sluggishness or weakness
- ☐ Dry skin
- ☐ Brittle nails
- ☐ Hair loss and/or coarse or dry hair
- ☐ Increased sensitivity to cold
- ☐ Constipation
- ☐ Memory problems or having trouble thinking clearly
- ☐ Heavy or irregular menstrual periods
- ☐ Weight gain
- ☐ Swelling of the arms, hands, legs, and fee
- ☐ Facial puffiness, especially around the eyes
- ☐ Hoarseness
- ☐ Muscle aches and cramps
- ☐ Low blood pressure
- ☐ Elevated blood cholesterol
- ☐ Infertility
- ☐ Sleep irregularities
- ☐ Depression

INFORMED CONSENT FOR THE BIOSCAN

Patient Name: _____ **Date:** _____

Background: I desire to be tested to determine possible undesirable reactions to various stressors that are natural constituents of my diet, environment or body chemistry. I understand that the device being used is FDA cleared for Galvanic Skin Response Testing and not intended to directly treat or cure any specific condition, symptom or illness. The physician has explained, and I understand, the benefits of receiving stress reduction and relaxation therapy and the direct relationship between stress, illness and disease.

Procedures: I understand that this is a non-invasive procedure (the skin is not pierced). A stylus or electrodes are attached to the skin to measure electrical conductivity on the hands. Homeopathic remedies, nutritional supplements and other natural remedies may be used to bring abnormal electrical patterns into equilibrium. I understand the nature of the immune system and related symptoms are unpredictable and therefore the facility cannot guarantee any results. PINE HILL FARM WELLNESS COLLECTIVE + MARKET cannot guarantee that new stressors will not contribute toward my health conditions in the future and that in some cases a person may not wholly respond to the treatment.
I choose to be tested with the Bioscan. I understand that this testing has not been scientifically proven to be reliable and that my physician must still rely upon my observations as to the efficacy of the test and any treatment based on the results of this test.

Risks: The procedure is very safe because it measures only changes in the electrical properties of the skin. However, since an electrical signal is used there is a slight risk or electrical burn or shock. Skin irritation or redness may occur at the site of the test. However, any discomfort should be brief. There are generally no risks associated with the substances recommended to bring your body to equilibrium as long as those substances are taken as recommended, but please report any discomfort you may experience from taking these substances to your examiner or physician. Please report any significant health problems (i.e. Diabetes, High Blood Pressure, etc.) to your physician. I understand that there is a risk factor where as a result of exposure to these bio-energetic stressors, that I may experience temporary symptoms not unusual to the regular symptoms currently experienced when exposed to these stressors. I assume all responsibility for the unpredictable immune reactions that may lead to increased symptoms. I agree to seek immediate medical attention should this occur and understand that this facility does not treat cases of patients suffering from anaphylactic allergic reactions and I agree to completely disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

Questions: I have been provided with the opportunity to ask any pertinent questions I have regarding the BioScan procedure, protocol or treatment program.

Free to Decline: I understand that I may decline to the BioScan testing and Processing.

Important: There is no recognized body of scientific evidence to show that an electrically balanced body is more likely to be healthier and you have chosen to participate in this assessment with that understanding. Your physician may need to use other forms of testing in the course of your treatment.

Payment of Services: You are responsible for the payment of the normal and necessary fees associated with the BioScan Assessment and services performed as a result of that testing, if purchased in this clinic.

I have read and understand the above information about the BioScan and my rights and responsibilities and hereby consent to the use of the BioScan. I consent to the use of clinical reports and results of my case for study, the purpose of advancing clinical knowledge, research and scientific purposes provided that my identity is kept confidential.

Patient's Printed Name: _____Signature: _____

Date: _____

IF YOU ARE UNDER 18 YEARS OF AGE, WHO ARE YOUR LEGAL PARENTS OR GUARDIAN?

Father: _____ Date of Birth: ____/____/____

Phone: (_____) _____

Mother: _____ Date of Birth: ____/____/____

Phone: (_____) _____

Guardian: _____ Date of Birth: ____/____/____

Phone: (_____) _____

Signature of Parent or Guardian: _____

Date: _____