Health Intake Forms

Patient Name:
_____

Date: _____

Address:
_____

Date of Birth:
_____

City, State, Zip:
_____

Phone Number:
_____

Gender: ☐ MALE ☐ FEMALE

Email: _____

Primary Care Physician:
_____

How did you hear about us?
_____

Primary Care Physician Phone Number:
_____

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;
- 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:

_____
_____
_____
_____

How motivated are you to achieve your healthcare goals?

☐ Baby Steps ☐ Moderate Changes ☐ I'm all in

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 & SUPPLEMENTS:

PLEASE LIST NAME/DOSE:

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? _____
_____

How often do you have a bowel movement? ☐ **Every day** ☐ **Few times a week** ☐ **Once a week**

FOOD RELATED SYMPTOMS:

☐ Symptoms flare 5-60 minutes after meals

☐ Some foods cause swelling of the mouth or tongue

☐ Some foods cause rashes or hives

☐ Some foods cause upset stomach or vomiting

☐ Some foods cause diarrhea

☐ Symptoms occur with restaurant salad bars or Asian foods

☐ Some foods cause headaches

☐ Preservatives, additives or food coloring increases symptoms

☐ No problem with foods

VACCINATIONS

Please select all the vaccinations that you have received:

☐ Any childhood vaccinations ☐ COVID-19 Vaccinations ☐ COVID-19 Boosters ☐ Influenza (flu shot)

(Please list which COVID-19 Vaccination you received)

_____

Have any of your illnesses or symptoms started after a vaccination or booster?

_____

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

Mouth & Throat Thrush
- ☐ gagging/clearing throat often
- ☐ sore throat/hoarse voice/voice loss
- ☐ swollen/discolored tongue/lips

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

- ☐ cancer sores
- ☐ itching on roof of mouth

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

Head:
- ☐ faintness
- ☐ headaches
- ☐ dizziness
- ☐ insomnia/sleep disorder

Other Conditions:

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

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 practitioner 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; therefore, the facility cannot guarantee any results. WELLNESS COLLECTIVE OF PINE HILL FARM 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.
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 very rare risk of mild electrical shock, skin irritation or redness at the site of the test (fingers). 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 practitioner. I assume all responsibility for any changes in symptoms. On rare occasions, you may experience allergy like symptoms that may be associated to the exposure of electrical dermal screening.

Questions: I have been allowed to ask pertinent questions regarding the BioScan procedure, protocol or treatment program.

Free to Decline: I understand that I may decline to the BioScan testing and Processing.
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. Our facility does take HSA as a form of payment.

I have read and understand the above information about BioScan and my rights and responsibilities and hereby consent to the use of 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.

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: _____