Global Transformation Pathways

Confidential Intake Form

Name: ________________________________ Hm #: _______________ Wk#: _______________ Cell#: _______________

Street: ____ City: ______________________ State: _______ Zip: _______

Email Address: ____

Date of Birth: _______________ Age: _____ M__ F__ Ht: ______ Wt: _____ Occupation: ___________________________

How did you hear about us? ____

Primary Reason for your visit today ____

Other concurrent therapies ____

Primary health goals: (list top 3 and rate on a scale of 1-10, i.e. pain relief, specific chronic health issue(s) relief, stress relief, detoxification, weight loss, sleep, etc…) Rate severity of symptoms (1-10)

1) ___________________Rating: ____ 2) ____________________ Rating: _____ 3)___________________Rating: _____

Describe in more detail any of above goals: ____

____

Name of Doctor: ___________________________________ Phone: _________________ Fax #: __________________

Address: ____ City: _______________________ State: ______ Zip ________

Doctors Diagnosis: ____

How are you responding in your present course of treatment? Better _____ Worse _____ Same _____

Date of last appointment with regular physician: ____________

Reason for that last appointment: ____

YOUR PAST MEDICAL HISTORY (include dates on last line)

( ) Cancer ( ) Diabetes ( ) Heart Disease ( ) Stroke ( ) Sexually Transmitted Disease

( ) Seizure ( ) Hepatitis ( ) Thyroid Disease ( ) Alcoholism ( ) High Blood Pressure

( ) Other ____

Dates: ____

FAMILY PAST MEDICAL HISTORY (include dates on last line)

( ) Cancer ( ) Diabetes ( ) Heart Disease ( ) Stroke ( ) Sexually Transmitted Disease

( ) Seizure ( ) Hepatitis ( ) Thyroid Disease ( ) Alcoholism ( ) High Blood Pressure

( ) Other ____

Dates: ____

Surgeries: ____

Significant Trauma: (Physical or Emotional) ____

____

Birth History: ____

Allergies: (drug, food, chemical, environmental) ______________________________________

Medicine taken in the past 2 months (medications, vitamins, and food supplements)

Name: ______________________________________ Dosage: ___________________________

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______________________________________ Dosage: ___________________________

Occupational Stresses: (chemical, physical, psychological, etc) _____________________________

Exercise: (type, duration, frequency) ____

Habits (Qty): ( ) Cigarettes – ea/pk ( ) Coffee - cups ( ) Soda # ( ) Tea - cups ( ) Caffeinated ( ) or Herbal ( )

Alcohol - # drinks/day ( ) Drugs - type ( ) Sugar - # srvgs/day Water – oz/day ( )

Avg Daily Diet: Morning ____

Afternoon ____

Evening ____

General:

( ) Poor Appetite ( )Fevers ( ) Poor Sleep ( ) Heavy Sleep ( ) Insomnia ( ) Fatigue ( ) Sweat Easily ( ) Tremors ( ) Cold Hands ( ) Cold Feet ( ) Cold Back ( ) Heavy Appetite ( ) Cold Abdomen ( ) Chills ( ) Vertigo ( ) Night Sweats ( ) Localized Weakness ( ) Poor Coordination ( ) Cravings ____ ( ) Sudden Energy Drop At ______________(time) ( ) Peculiar Tastes or Smells ( ) Strong Thirst (cold/hot drinks) ( ) Bleeds/Bruises Easily (where) ____________________ ( ) Varicose/Spider Veins

SKIN/HAIR

( ) Rashes ( ) Pimples ( ) Ulcerations ( ) Dandruff ( ) Loss of Hair ( ) Change in Texture ( ) Hives ( ) Itching ( ) Eczema ( ) Other hair/skin problems _______________________________________

HEAD,EYES,EARS,NOSE,AND THROAT

( ) Dizziness ( ) Eye Pain ( ) Sinus Problems ( ) Poor Hearing ( ) Jaw Clicks ( ) Ringing in Ears ( ) Concussion ( ) Mucus ( ) Poor Vision ( ) Earaches ( ) Nose Bleeds ( ) Eye Strain ( ) Floaters ( ) Facial Pain ( ) Color Blindness ( ) Glasses ( ) Night Blindness ( ) Migraines ( ) Cataracts ( ) Dry Mouth ( ) Grinding Teeth ( ) Dry Throat ( ) Teeth Problems ( ) Headaches (where, when, & frequency (how often?))____

CARDIOVASCULAR

( ) High Blood Pressure ( ) Chest Pain ( ) Fainting ( ) Irregular Heart Beat ( ) Cold Hands/Feet ( ) Low Blood Pressure ( ) Blood Clots ( ) Dizziness ( ) Swollen Hands/Feet ( ) Difficulty Breathing

RESPIRATORY

( ) Coughing Blood ( ) Cough ( ) Asthma ( ) Bronchitis ( ) Pneumonia ( ) Tight Chest ( ) Production of Phlegm ( ) Difficulty Breathing when Lying Down

GASTROINTESTINAL

( ) Nausea ( ) Vomiting ( ) Diarrhea ( ) Hemorrhoids ( ) Belching ( ) Black Stools ( ) Gas ( ) Bad Breath ( ) Rectal Pain ( ) Pain/Cramps ( ) Constipation ( ) Bloody Stool ( ) Sensitive Abdomen BOWEL MOVEMENT: Frequency _______________ Color _____________________

GENITO-URINARY

( ) Pain on urination ( ) Wake up to Urinate ( ) Kidney Stones ( ) Urgency to Urinate ( ) Impotency ( ) Incontinence ( ) Frequent Urination ( ) Blood in Urine ( ) Venereal Disease ( ) Other ____________________

PREGNANCY & GYNECOLOGY

( ) Irregular Periods ( ) Clots ( ) Discharge ( ) Sores ( ) Breast Lumps ( ) Menopause # of pregnancies ___ # of Births ____

#Premature ____ #Miscarriages ____ Age at first menses _____ Period Duration ________ Last Menses __________ Birth Control ________

MUSCULOSKELETAL (please also note pain level 1-10, 10 being highest)

( ) Neck Pain (where) ________________________________ ( ) Muscle Pain (where) ___________________________________

( ) Back Pain (where) ________________________________ ( ) Joint Pain (where) _____________________________________

NEUROPSYCHOLOGICAL

( ) Poor Memory ( ) Seizures ( ) Areas of Numbness ( ) Concussion ( ) Depression ( ) Anxiety ( ) Anger Easily ( ) Easily Stressed

( ) Considered/Attempted Suicide ( ) Other Neurological or Emotional (specify) ____

RATE THE FOLLOWING:

Energy Level on Average (1-10, 1 being low, 10 being very good/high) ______

Comments : ____

Mental Clarity/Brain Fog (1-10, 1 being very foggy and memory compromised, 10 being very clear) ______

Comments: ____

Sleep Quality on Average (1-10, 1 being poor, 10 being very good/sound) _______

Comments: ____

Digestion on Average (1-10, 1 being low, 10 being very good/high) ______

Comments : ____

Sense of Joy/Well Being/Contentment on Average (1-10, 1 being poor, 10 being very good) _______

Comments: ____