##### **Intake Form - Adult**  Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Male \_\_\_\_\_ Female\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_

Address (may need to mail you remedies): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(work/cell)

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact (name and phone number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Separate/Divorced \_\_\_\_\_ Widow

Your primary occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How would you describe your general state of health currently? Consider common indicators: general disposition, energy level, quality of sleep, sex drive, appetite, digestion. Be as specific as possible. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. List your **primary health concerns** in order of importance (could be physical, mental, emotional. (write on back page if needed)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What are some of the **stressors** in your life (your child's life) right now? Rate on scale of 1-10

Work \_\_\_\_\_ Family \_\_\_\_\_ Social \_\_\_\_\_ Finances\_\_\_\_\_ Health\_\_\_\_\_ Other\_\_\_\_\_ describe

4. What is the emotional climate of your home like right now?

5. When was the last time you felt really well from a health perspective? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Are you aware of any allergies to medicine, food, environment? Yes \_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please list known/suspected allergies as well as approximate time of identification.

|  |  |
| --- | --- |
| **Allergy** | **Date** |
|  |  |
|  |  |
|  |  |

7. Any serious illness? Type: When?

**REGIMEN - (Nutrition, Hydration, Dormition, Recreation)**

Blood type: \_\_\_\_\_\_\_\_\_ ( O, B, A, AB ) Handedness (right or left?) : \_\_\_\_\_\_\_\_\_

**Nutrition**

8. Do you eat three meals per day? Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_

9. What do you eat on a typical day? Please add meal times.

Breakfast \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. How much protein do you eat per day? (a 4 oz (100gr) chicken breast is 30 gr protein, one large egg is 6 gr, 1 cup yogurt is 8 gr). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hydration**

11. Please answer these questions: which do you consume, and how often?

|  |  |  |  |
| --- | --- | --- | --- |
| Fluid | Yes | No | Quantity per day or week |
| Water |  |  |  |
| Fruit Juice |  |  |  |
| Coffee |  |  |  |
| Herbal tea |  |  |  |
| Milk |  |  |  |
| Alcohol |  |  |  |
| Soda/diet soda |  |  |  |
| Black tea |  |  |  |
| Other |  |  |  |
|  |  |  |  |
| Do you smoke? |  |  |  |
| Do you get sunlight daily? |  |  |  |

**12.** What types of food do you typically crave and when? (ex. sweets when I'm low energy, chips when I'm stressed, fatty food all of the time)

**Dormition - Sleep**

13. Do you awake refreshed and well? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Average number of hours you sleep each night: \_\_\_\_\_\_\_\_Trouble falling asleep: \_\_\_\_ Yes \_\_\_\_\_No

15. What is your usual bedtime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your wake time? \_\_\_\_\_\_\_\_\_\_\_\_ Alarm clock? \_\_\_\_\_\_

16. Do you think that you sleep well? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

17. Describe your sleep routine (time, habits, restlessness, night terrors, sleep apnea)

|  |  |
| --- | --- |
| **RECREATION/EXERCISE** |  |

17. Do you exercise? \_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_ No

|  |  |
| --- | --- |
| **Type of Exercise** | **Frequency** |
|  |  |
|  |  |
|  |  |

18. Do you spend time outdoors?

Daily \_\_\_\_\_\_\_\_ Couple of times a week \_\_\_\_\_\_\_\_\_ Weekly \_\_\_\_\_\_\_\_\_ Only if necessary \_\_\_\_\_\_\_\_\_

19. Describe what you normally do to relieve stress (meditate, read, walk, talk, take a bath….)

**FAMILY HISTORY**

20. Please indicate any family members (father, mother, grandparents, siblings, children) who have had, or currently have the following conditions (add a new condition if not listed):

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Family member** | **Condition** | **Family member** |
| Alcoholism  |  | Cancer  |  |
| Allergies  |  | Cataracts  |  |
| Arteriosclerosis  |  | Celiac Disease  |  |
| Arthritis  |  | Crohns/Colitis  |  |
| Asthma  |  | Depression  |  |
| Bed wetting  |  | Diabetes  |  |
| Birth Defects  |  | Epilepsy  |  |
| Blindness  |  | MS  |  |
| Heart Disease  |  | Osteoporosis  |  |
| Hyperactivity  |  | Ulcers  |  |
| Kidney Disease  |  | Stroke  |  |
| Learning Disability  |  | TB  |  |
| Mental Illness  |  | Yeast Infections  |  |
| Migraines/headaches |  | Other |  |
|  |  |  |  |
|  |  |  |  |

21. Have you had in the past or do you currently have any of the following conditions/symptoms?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition/Symptom**  | **PAST** | **PRESENT** |  | **PAST** | **PRESENT** |
| Acne  |  |  | Urgency to Void urine |  |  |
| Allergies  |  |  | Inability to Void urine |  |  |
| Asthma  |  |  | Frequent Urinary Infection  |  |  |
| Bronchitis  |  |  | STDs (sexually transmitted disease) |  |  |
| Emphysema  |  |  | Unusual discharges |  |  |
| Eczema  |  |  | Painful menses |  |  |
| Hives  |  |  | PMS |  |  |
| Headaches  |  |  | Joint pain/stiffness |  |  |
| Migraines  |  |  | Arthritis |  |  |
| Dizziness  |  |  | Osteoporosis |  |  |
| Hayfever  |  |  | Osteopaenia (pre-osteoporosis) |  |  |
| Glaucoma  |  |  | Broken bones |  |  |
| Cataracts  |  |  | Muscle weakness |  |  |
| Hearing Loss  |  |  | Joint swelling |  |  |
| Ringing in Ears  |  |  | Back pain |  |  |
| Sinus Problems  |  |  | Concussion |  |  |
| Frequent Sore Throat  |  |  | Varicose veins |  |  |
| Gingivitis  |  |  | Thrombophlebitis |  |  |
| Dental Cavities  |  |  | Leg cramps |  |  |
| Goitre  |  |  | Cold hands/feet |  |  |
| Pneumonia  |  |  | Fainting |  |  |
| Wheezing  |  |  | Seizures/convulsions |  |  |
| Difficulty Breathing  |  |  | Paralysis |  |  |
| Shortness of Breath  |  |  | Loss of memory |  |  |
| Tuberculosis  |  |  | Speech problems |  |  |
| Heart Disease  |  |  | Thyroid problems |  |  |
| Angina  |  |  | Diabetes |  |  |
| High Blood Pressure  |  |  | Hormone therapy |  |  |
| Low Blood Pressure  |  |  | Anemia |  |  |
| Heart Murmur/ Palpitations  |  |  | Easy bleeding/bruising |  |  |
| Breast Lumps  |  |  | Blood transfusion |  |  |
| Breast Pain  |  |  | Leukemia |  |  |
| Trouble Swallowing  |  |  | Cancer |  |  |
| Heartburn  |  |  | Vaccine reactions |  |  |
| Unusual Thirst  |  |  | Depression |  |  |
| Unusual Hunger  |  |  | Anxiety |  |  |
| Nausea  |  |  | Phobias |  |  |
| Gas/Belching  |  |  | Bilolarism |  |  |
| Jaundice  |  |  | Alcohol abuse |  |  |
| Liver Disease  |  |  | Drug abuse |  |  |
| Gallbladder Disease  |  |  | Insomnia |  |  |
| Ulcers  |  |  | HIV |  |  |
| Prolonged Diarrhea  |  |  | AIDS |  |  |
| Bloody Stools  |  |  | ADD-attention deficit disorder |  |  |
| Constipation  |  |  | ADHD- “ and hyperactivity disorder |  |  |
| Indigestions  |  |  | PTD-post traumatic disorder |  |  |
| Hemorrhoids  |  |  | OCD-obsessive-compulsive disorder |  |  |
|  |  |  |  |  |  |

22. Please list all Prescription Medications that you are **currently** taking:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dose** | **Reason** | **Date started** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

29. Please list all **Vitamins/Supplements/Homeopathic** Medications that you are currently taking:

|  |  |  |  |
| --- | --- | --- | --- |
| **Supplement** | **Dose** | **Reason** | **Date started** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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30. Additional information you would like me to know …

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***CONSENT TO TREATMENT***

*I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ enter with full consent into a professional relationship with Sonia Jaramillo. I am aware that she is a Heilkunst Homeopath. She has told me about the scope of her practice and the educational experiences that support her skill base. She has informed me that she will use Heilkunst treatment, sequential timeline treatment with homeopathy, as well as dietary and lifestyle recommendations. She informed me that she is not a Medical Doctor. She has also informed me that the education she may provide is not intended to “treat” or “cure” any disease, nor is it seen as a replacement for the care of a physician, psychiatrist, or other health care provider. I voluntarily consent to therapeutic procedures including physical, mental, emotional and spiritual aspects, except the following \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.*

*Please sign and print your name below to indicate that you have read the above statements and willingly agree to enter into a professional relationship with Sonia Jaramillo.*

*Signature of Client(s) (or Legal Guardian):*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_*

***CONFIDENTIALITY***

*I understand that all information and records generated and obtained in the course of treatment will remain confidential within Sonia Jaramillo’s practice and will not be released to other parties without my written consent. This confidentiality will be followed according to the Health Information Portability and Accountability Act (HIPAA).*

 *I have read and understand the contents of this consent form and accept the conditions of this agreement.*

 *Signature of Client(s) (or Legal Guardian):*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_*