ILLUMINA HEALTH
CRYO & WELLNESS CENTER

Medical History Intake Form

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____ **Date**_____

City _____ **State** _____ **Zip Code** _____

Leave Messages on: (Circle one**)** Home Cell Work Don't leave messages

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ Age____ **Sex:** □ Male □ Female

Occupation _____ **Marital Status:** □ Single □ Married □ Other

Emergency Contact: Name _____ **Relationship**_____

Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

Current Height _____ **Current Weight** _____

How did you hear about us? _____

What brings you here? _____

_____

_____

_____

List your desired healthcare **goals** or **concerns** according to **priority**

1._____

2._____

3._____

Stress Level: 0 1 2 3 4 5 6 7 8 9 10 0= no stress 10 = very stressed

Quality of Sleep 0 1 2 3 4 5 6 7 8 9 10 0= poor 10=good

Medical Conditions: (Circle all that apply to you)

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Raynaud's Syndrome	□ Anger/Irritability	□ Mood Swings	□ Memory Loss
□ Fibromyalgia	□ Asthma	□ Osteoporosis	□ Seizures
□ Headaches / Migraines	□ Lung disorder	□ Tuberculosis	□ Eczema

□ Other _____

Surgeries: (Circle all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia
□Breast Augmentation	□ Metal implants	□ Other _____	

Allergies: (Circle all that apply to you)

□ Mold	□ Seasonal	□ Milk or Lactose	□ Animal
□ Chemical _____	□ Sulfites	□ Wheat/Glutens	□ Other _____

Social History: (Circle all that apply to you)

Caffeine use:	□ occasional	□ often	□ never	
Drink Alcohol:	□ occasional	□ often	□ never	
Exercise:	□ occasional	□ often	□ never	
Drink Water:	□ <64 oz./day	□>64 oz./day	□ never	
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never	□ previous Smoker
Sleep:	□<8 hours/night	□ >=8 hours/night	□ Insomnia	

Other _____

Family History: (Circle all that apply)

Arthritis:	□ Parent	□ Sibling	Hypertension	□ Parent	□ Sibling
Cancer:	□ Parent	□ Sibling	Stroke	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling	Thyroid	□ Parent	□ Sibling
Heart Disease	□ Parent	□ Sibling	Other _____		

Dental History: (Circle yes or no) Metal Fillings Y N Root Canal Y N

Women ONLY (circle yes or no):

Are your periods regular? yes no

Are you pregnant? yes no

Do you plan in becoming pregnant anytime soon? yes no

Menopause? yes no

Please list all current medications being taken _____

_____

_____

_____

Review of Systems – (Check box if you have had trouble with any of the following)

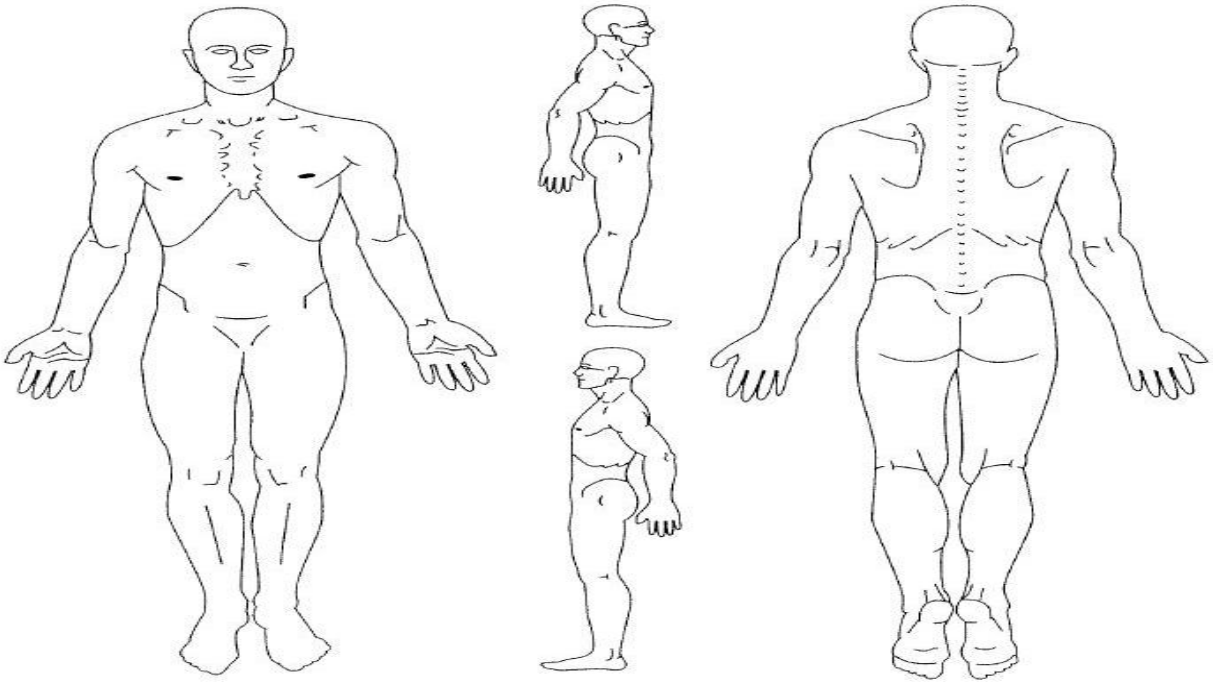
Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

(Office use only Notes:)

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

Last 24 hours:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain
Past week:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain

Does anything improve your pain? Yes No **If Yes, please list:**

When did your symptoms begin? _____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident
□ Other_____

How did your symptoms begin? _____
_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day)	□ Frequently (51-75% of the day)	□ Occasionally (26-50% of the day)	□ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

□ Sharp	□ Ache	□ Numb	□ Shooting
□ Burning	□ Tingling	□ Throbbing	□ Other _____

Diet and Nutrition: Check all that apply:

1. Are you on any special diet type? name diet_____
2. Number of times you eat per day ( )
3. Amount of water/daily _____ozs
4. Do you have a history of: compulsive or binge eating ( ) eating disorder ( )
5. What does your main meal consist of and how is it prepared?
   □Freshly home-cooked produce □Restaurant meal □ Pre-cooked, microwave or TV dinners
6. What foods do you have an affinity for? □ sweet foods □ salty foods □ savory □sour
7. Have you ever been tested for food allergies, or sensitivities?
8. Do you consume dairy or dairy by- products, and what kinds?
   (If yes) How often during the week?
9. Do you consume fast foods and soda beverages?

Lifestyle

On a scale of 1-10 (1= not very important, 5 = somewhat important, and 10 = very important)

a) How important is it for you to make lifestyle changes such as adjusting your diet, increasing your physical activity, and changing health-related behaviors? _____

b) How ready are you to make lifestyle changes? _____

c) How confident are you that you can make lifestyle changes? _____

1. What lifestyle changes would you be willing to make?

_____

_____

2. What things might make it hard for you to make lifestyle changes?

_____

_____

Physical Activity

1. Do you participate in regular physical activity?
   o No. What exercise do you like to do? _____
   o Yes. What type (s)? _____
   How long? _____ How many times a week? _____

2. Do you practice mediation or other spiritual exercises?

WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT. Please initial each line

Whole Body and Local Cryotherapy, Pulse Electro Magnetic Field Therapy, PEMF Guided, Exercise with Oxygen Therapy, Photon Genius Heat Therapy, Photon Genie, Low Light Laser Therapy, Colon Hydrotherapy, Chiropractic Services, IV Therapy, Compression Therapy, Shockwave Therapy, Lymphstar, Massage Therapy

____1. My signature and initials constitutes my acknowledgment that (1) I have read, understand, and fully agree to the foregoing CONSENT, (2), I hereby give my authorization and consent. This CONSENT shall stand as long as I use the Equipment listed above at the location now and in the future.

____2. In consideration for using the therapeutic modalities, I bind the members of my family and spouse (if any), if I am alive, and my heirs, assignees and personal representative hereby RELEASE, WAIVE, DISCHARGE, and HOLD HARMLESS Illumina Health, its officers, servants, agents, employees and volunteers (hereinafter referred to as RELEASEES) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, medical costs or injury, that may be sustained by any person, while using the equipment or due to the use of the equipment.

____3. I hereby confirm that no warranty or guarantee, or other assurance, has been made to me covering the results of the therapeutic modalities. I fully understand the administration of the process, including possible adverse reactions, side effects, or other possible complications. It is understood that this CONSENT is being given in advance of any administration of the process, and is being given by me voluntarily to use the Equipment.

____4. I am at least eighteen (18) years of age (or if under 18 present with legal guardian), and fully competent; and I execute this Release for full, adequate, and complete consideration fully intending to be bound by same. Furthermore, I agree that I will comply with all instructions on the use of the therapeutic modalities and that I am using these services at my own risk. I agree to use all sessions within the terms of the contract dates and understand that refunds are not given on unused portions of purchased packages.

____5. I hereby consent to have my patient information shared with all practitioners of the clinic as deemed necessary by my treatment plan.

I understand that the therapeutic modalities are not a replacement for being under the care of a physician and I have fully disclosed all of my medical diagnoses and/or conditions. I understand I have been given the opportunity to ask any pertinent questions and have been informed that I have the option to consult with the Drs on staff.

_____ _____ _____

Printed Name Signature Date

_____

Participant Parent or Legal Guardian Signature