Case Intake Form
HealScape Holistics

Note: The purpose of this case form is to get complete information, some of which might be missed during case intake. When filled carefully and honestly, this form will to help me get information to treat you better. If you prefer to just speak rather than fill the form, please read it carefully and note down points you would like to discuss or mention, and fill in this form with as much detail as possible and submit it before your first appointment.

Rest assured that all information is *private and confidential.*

I WAS RECOMMENDED TO YOU BY: _____
DATE: _____
NAME: _____ DATE OF BIRTH: _____ SEX: _____
ADDRESS: _____
_____
CITY: _____ ZIP: _____ STATE: _____

Phone: (HOME): _____ (WORK): _____ (CELL): _____
EMAIL: _____
PRIMARY CARE PHYSICIAN:
_____
OCCUPATION:
_____
HOBBIES AND INTERESTS:
_____

MARRIED/SINGLE/DIVORCED/SEXUAL PREFERENCE: _____
CHILDREN: _____

Main Complaint:

Describe your complaint in detail…what exactly happens, when, how often, how long it lasts. How did it begin?

HEALTH HISTORY

Please give details of the health history of your relatives including, parents, grandparents, siblings, uncles and aunts:

Anything unusual about your own birth?

Were you breast-fed or were on formula?

Please list all the vaccines taken so far

Any adverse reaction to any vaccine?

Please list any surgery at any stage of life, including the list of medication taken

List any medication you are currently taking including contraception, Cannabis products, Vitamins and Food Supplements:

Details about anything that you are allergic to:

Any skin issues?

APPETITE & THIRST

What foods/drinks/flavours/condiments etc. do you either crave or have Strong dislike of?

Does any food or drink cause health issues?

How naturally thirsty are you?

When do you feel more thirst during the day?

How is your appetite? When do you feel hungry during the day?

What happens if you have to remain hungry for long time?

Do you feel any change in your taste and feeling in your mouth? At any particular time?

Any habits or addictions, like smoking etc.?

What are your fears? For example heights and ghosts etc.

<u>SLEEP:</u> Waking up at night, difficulty sleeping, or going back to sleep?

Describe your posture during sleep, on the back, side, abdomen etc.

In which position you just can't sleep?

During sleep do you: Snore? Grind teeth? Dribble saliva? Sweat? Keep eyes or mouth open? Walk? Talk? Moan? Weep? Laugh? Become restless? Wake up with a jerk?

DREAMS: Any dreams that stay in your memory. Any recurring dreams. Include childhood dreams. Please try to recall at least one dream that you have had in your life.

Please describe any unusual memories from childhood

WEATHER & ENVIRONMENT REACTION:

What weather suits you best? Cold/heat/wind/drafts/damp/humidity?

Do you prefer warm rooms or desire fresh air etc.?

Do you like company, or prefer to remain alone?

How seriously are you affected by disorder and uncleanliness in your surrounding?

What activities you deeply like, or/and deeply dislike?

Describe headaches and/or migraines if any

MENSTRUATION:
Regular / Irregular, number of days, colour?

Conditions before, during and after menstruation

Finally:

If you are given complete freedom to create the IDEAL WORLD, what kind of a world would you create? Please describe the details. You may want to add another sheet of paper if need be.