Confidential Medical History

_____ desires to ensure the safety of all participants. In order to assist in this regard, Please complete the following Application and Confidential Medical History Form.

Any information obtained herein is strictly confidential and is used to determine if it is appropriate for you to participate in our program. Please complete every item in every section.

Mark N/A if any section is not applicable. If you are mailing this form to the _____ , please keep a copy for your records.

Participant Legal Name: _____

Preferred Name (if different) _____

Gender: □ Female □ Male □ Transgender FTM □ Transgender MTF □ Other _____

Height: _____feet/inches cm Weight_____lbs kg

Date of Birth: _____Current Age _____

Address: _____
City _____State_____Zip:_____

Cell Phone:_____ Home Phone (if different):_____
Do we have your permission to leave personal information at this phone number?
Cell Phone Voice mail: □ Yes □ No Text: □ Yes □ No
Home Phone Voice mail: □ Yes □ No

Email:_____
Do we have your permission to discuss personal information at this email? □ Yes □ No

Emergency Contact:_____
Primary Care Physician:_____Phone Number:_____

How did you hear about us?_____

Medical History

The following pages are for your complete medical history. Certain medications and supplements can interact with the herbal properties of ayahuasca (*Banisteriopsis caapi* and *Psychotria viridis)*. A complete list of your current medications, drugs herbs, supplements, and health history is important for your overall safety and enjoyment of your experience. Your answers are absolutely confidential, so please answer as honestly as possible.

Current Medications

Medication	Dosage & Frequency	Reason for Taking

Do you take any MAO inhibitors? Examples include Marplan, Nardil, Niamid, Parnate, Jatrosom, and Emsam.

□ Yes (please list in the table above)

□ No

Do you use any SSRI's? Examples include Zoloft, Celexa, Lexapro, Luvox, Paxil, Prozac,
Viibryd, and Symbyax.

□ Yes (please list in the table above)

□ No

Do you take any tricyclic antidepressants? Examples include Anafranil, Tofranil, Vivactil, Nortriptyline, Amitriptyline, Imiprex, and Amoxapine.

□ Yes (please list in the table above)
□ No

Do you use an asthma inhaler or take any asthma medications?
□ Yes (please list in the table above)
□ No

Do you use any amphetamines? Examples include Adderall, Ritalin, Concerta, & Vyvanse.
□ Yes (please list in the table above)
□ No

Do you take any narcotic pain killers? Examples include Oxycodone, Vicodin, Codeine, Dilaudid, Duragesic (fentanyl), Demerol, Norco, Lorcet, Methadone and Heroin.
□ Yes (please list in the table above)
□ No

Do you use any of the following over-the-counter products?
□ Sudafed, Aleve, Allegra, Benadryl Plus,, or any other products that contain pseudoephedrine
□ Theraflu, Sudafed PE, Vicks Sinex Nasal Spray, or any products that contain phenylephrine
□ NyQuil, Delsym, Robitussin, Zicam, or any other products that contain dextromethorphan

Do you drink alcohol?
□ Yes Please estimate the number of alcoholic drinks you consume per week:_____
□ No □ I am sober / in recovery

Do you use tobacco?
□ Yes How much do you per week?_____cigarettes / cigars / pipe tobacco / chew
□ No □ I am a past smoker / tobacco user

Have you ever had a substance abuse issue?
□ No
□ Yes: Past □ I am sober / in recovery

□ Yes, Current Please describe:

Have you ever been hospitalized for any psychiatric or emotional issue?
□ No
□ Yes Please describe:

Are you currently in counseling?
□ No
□ Yes Type of counseling:_____
Reason for counseling:_____
Counselor's Name_____Phone Number_____

Are you currently experiencing any emotional/psychological crises?

Are you currently experiencing significant emotional, physical, or psychological stress?

Is there anything else about your mental or emotional status we should be aware of ?

Current Herbal Medicines and Nutritional Supplements

Herb or Supplement	Dosage & Frequency	Reason for Taking

Are you taking St John's Wort?
□ Yes (please list in the table above)
□ No

Are you taking any supplements that contain L-tryptophan?
□ Yes (please list in the table above)
□ No

Please list any allergies (medication, food, environmental, etc):

What are you allergic to?	Reaction	Severity

Current and Past Medical Conditions

Are you currently pregnant? □ Yes □ No

Have you ever experienced any of the following:

Joint pain or injury □ Yes □ No □ Current □ Past Please describe:

Migraines □ Yes □ No □ Current □ Past Please describe:

Head or brain injury □ Yes □ No □ Current □ Past Please describe:

Fainting □ Yes □ No □ Current □ Past Please describe:

Seizures □ Yes □ No □ Current □ Past Please describe:

Depression □ Yes □ No □ Current □ Past Please describe:

Anxiety □ Yes □ No □ Current □ Past Please describe:

Suicidal thoughts or attempts □ Yes □ No □ Current □ Past Please describe:

Post Traumatic Stress Disorder □ Yes □ No □ Current □ Past Please describe:

Bipolar disorder □ Yes □ No □ Current □ Past Please describe:

Schizophrenia □ Yes □ No □ Current □ Past Please describe:

Vision problems □ Yes □ No □ Current □ Past Please describe:

Reduced hearing □ Yes □ No □ Current □ Past Please describe:

Heart attack □ Yes □ No □ Current □ Past Please describe:

Angina □ Yes □ No □ Current □ Past Please describe:

High Blood Pressure □ Yes □ No □ Current □ Past Please describe:

Heart arrhythmia? □ Yes □ No □ Current □ Past Please describe:

Stroke or embolism? □ Yes □ No □ Current □ Past Please describe:

Asthma? □ Yes □ No □ Current □ Past Please describe:

Emphysema? □ Yes □ No □ Current □ Past Please describe:

Bronchitis? □ Yes □ No □ Current □ Past Please describe:

Hepatitis? □ Yes □ No □ Current □ Past Please describe:

Other liver diseases? □ Yes □ No □ Current □ Past Please describe:

Cancer? □ Yes □ No □ Current □ Past Please describe:

Crohn's disease? □ Yes □ No □ Current □ Past Please describe:

Ulcerative colitis? □ Yes □ No □ Current □ Past Please describe:

Irritable Bowel Syndrome? □ Yes □ No □ Current □ Past Please describe:

Frequent vomiting or nausea? □ Yes □ No □ Current □ Past Please describe:

Thyroid disorder □ Yes □ No □ Current □ Past Please describe:

Diabetes □ Yes □ No □ Current □ Past Please describe:

Low blood sugar □ Yes □ No □ Current □ Past Please describe:

The information provided above is a complete and accurate statement of the physical and psychological factors which may affect my participation in the ceremonies. I realize that failure to disclose such information could result in harm to me and fellow participants and I agree to indemnify and hold harmless _____ and its assistants if all relevant information is not disclosed. I also agree to notify _____ should there be any changes in my health status.

Print Name:_____

Signature_____Date_____

Thank you!