Heilkunst Intake Form

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All information on these forms is kept strictly confidential. If you need additional space, use the back of the page.

Name:_____ Date:_____

Birthdate: _____ Address:_____

E-mail address: _____ *Phone: (H)_____ (C)_____

Blood Type (O, A, B, AB): _____ ** (Please specify the best number to use)*

Please answer the following questions as best as you can, with as much information as possible.

What is your main health concern/complaints, both physical and emotional? Please list in priority:

What do you hope to achieve through this consultation service?

Have you experienced any major physical or emotional traumas in the past few weeks/months? If yes, please explain.

Rate your level of stress that you are experiencing in the past few weeks to months? (1 being low stress to 10 being highest stress)

What are the contributing factors to your stress? (list all that apply, IE. financial, family, career, spiritual, personal, unfulfilled expectations, marriage, children, health)

Do you have any tools which you utilize for managing or reducing stress?

Physical activity level: (frequency, type, time of day and duration)

Do you have any lows or peaks in energy throughout the day?

How many hours do you sleep (including naps)?

What time do you go to bed? Wake up?

Do you wake in the night, what time and what is the cause?

Do you have trouble falling asleep or staying asleep?

What is your occupation?

Do you enjoy your work?

What hours do you work (each day/per week)?

Regular schedule or shift work?

Do you smoke or use recreational drugs? How much and for how long? Are you influenced by second hand/ third hand (smoky clothes from other people)?

Do you consume alcohol? How often and how much?

What do you spend your time doing? (television, computer, work, driving, recreation/relaxation, hobbies)

Medical history

Please list doctor(s) and any other practitioners that you are currently seeing (chiropractic, naturopath, etc.):

Are you currently taking any medications? (list all medications, reason and amounts, including birth control)

Have you used antibiotics in the past five years? If yes, when and for what and how long?

List any supplements that you are currently using including type, frequency and dose:

Do you have any allergies (including anaphylaxis) or sensitivities? Please list:

Have you been diagnosed with an illness? Please explain:

Do you have your gallbladder? Adenoids or Tonsils? Appendix?

Have you had kidney stones or gall stones? If yes, when and what was treatment?

Have you experienced parasites or fungal infections (including yeast infections/bladder infections)? If yes, were you treated, and if so, what was treatment?

Have you travelled to a foreign country in the last 10 years?

How often do you have a bowel movement (including time of day)?

What is the consistency (firm/soft) of bowel movements?

Family History

Is there any family history of physical or mental illness? List all that apply:

Females

Are you pregnant? If yes, what week are you in and is this your first pregnancy?

Are you pre-menopausal? Post menopausal? If yes, are you experiencing any symptoms?

What is your menstrual flow like (frequency, duration, flow, clotting)?

Do you experience PMS symptoms? If yes, what are your symptoms (physical and emotional)?

Have you ever used oral contraceptives? If yes, for how long?

Males

Have you experienced any changes in frequency of urination or prostate problems? If yes, please explain:

Nutritional patterns

What are your food choices (meat eater, vegetarian, vegan, paleo, etc.)?

Do you avoid any foods? If yes, what and why?

How often do you eat? (1-3x/day, 1-7x/week, monthly)

Fruit/veggies _____ Protein _____

Dairy products_____ Fats (please list your source of fats) _____

Grains _____ _____

Fast food _____ Sweets and starches _____

Deli meats _____ Artificial sweeteners _____

Margarine _____

Main meals and snacks: do you eat more often sitting and relaxed or on the go:

How often do you use microwave, aluminum pans/foil?

How many cups do you drink of water (tap, bottled, purified), tea, coffee, juice, pop, milk, other beverages (including alcohol)?

Please list:

What is your favourite go to comfort food(s)? How often do you eat them?

Do you experience any symptoms if meals are missed? Explain:

Do you experience any symptoms after meals? Explain:

Please add anything other information that you think is important for us to best assist you with your goals

Terms & Conditions

- I understand and acknowledge that **Audrey Miller**, DHHP, DMH, LCM is not a medical Doctor nor is licensed to practice medicine.
- I understand this Live & Layered Blood Analysis will provide me with a graphic view of my blood physiology but is NOT a medical test and is not intended to be a substitute for conventional medical care by a trained Physician or Specialist.
- I understand no diagnosis or prescription will be given and the services she provides are always restricted to a consultation about health matters, including offering therapeutic education and making regimental and homeopathic recommendations. Any suggested nutritional therapy or homeopathic medicines is not intended as a primary treatment for disease, disorders or symptoms. The added schedule is intended to improve the quality of foods, diet and assimilation.
- I understand that lifestyle, eating habits, exercise, nutritional balance and mental state may affect what is seen during the analysis and therefore the results may vary between analysis conducted at different times.
- I agree to hold harmless, the Heilkunst Homeopathic Practitioner "Audrey Miller", who suggests or offers any homeopathic medicines or supplements to support or increase my state of health
- This statement has been signed voluntarily.

☐ I agree to the **cancellation policy** of this clinic: At least **24 hours notice** will be given to cancel an appointment. A fee of **half of the price of a consultation** will be charged if the above appropriate time is not given or for missed appointments.

Date: _____ Name: _____

Signature: _____

Do you consent to emails from Reviviscent Health regarding specials, promotions, information and/or events which are applicable to your health? Yes or No _____

All information contained in these forms is used for consultations only and is kept strictly confidential.

Submit