Triage' HEALTH INTAKE FORM

Name:____Date: __________________

Email:____ Phone #:_____________________

*Age: _______________ *Weight: ________________ *Height: ________________

☐ I, _____________________(name) give consent for the following information to be shared with The Joy Centers Healing Association team of practitioners understanding that it will be used to curate a plan of care on my behalf.

I give consent for this information to be shared with Joy Centers HA Team, Associate Professionals (list any other family or professionals you wish us to share with)_____________________________

____

We at Joy Centers Healing Association are neither a MD or ND. We do not diagnose, treat, prescribe or cure. We have varying degrees, licenses, certifications and training as a health ministerial team including nursing, Massage Therapy, MH (Master Herbalist), Natural Holistic Remedies, Emotion Code, Body Code and various other emotional and natural healing modalities. We cannot predict how each protocol will specifically work for you; each body is so uniquely different. Always refer to your medical care provider for questions about your health. We have a team of practitioners that will be overseeing as well as giving input on care following this intake form (if you agree to that).

*The information I provide is not intended to be a substitute for medical treatment but instead to help support or bolster what concerns arise. Please consult your medical care provider before using herbal medicine, particularly if you have a known medical condition or if you are pregnant or nursing. You are responsible for your own health. As with conventional medicine, herbal medicine is vast and complex, and must be used responsibly. Some herbs are contraindicated with certain pharmaceutical drugs.

Signature:____ Date:_______________

TOP 3 PHYSICAL, EMOTIONAL OR SPIRITUAL GOALS YOU WOULD LIKE HELP ACHEIVING:

1.____

2.____

3.____

***Chief Complaint or Concern:**

Emotional and Spiritual History:

I am currently seeing a professional for mental/emotional health support? Yes ☐ No ☐

I have a religious affiliation? No Yes What is your spiritual orientation or background?

____

I have spiritual support (If so explain):____

____

____

Spouse/Partner (if applies):

Name:____

I have emotional support from partner Yes ☐ No ☐

Spiritual support from partner Yes ☐ No ☐

Family of Origin:

My parents are still living Father Yes ☐ No ☐ Mother Yes ☐ No ☐

Siblings Yes ☐ No ☐ Where are you in birth order:____________________________________

Have you lost any siblings? ____

I have good family support (on a scale of 0-5; 5 being Great Support) 0 1 2 3 4 5

Social Community

I have a social connection (on a scale of 0-5; 5 being Great Support) 0 1 2 3 4 5

I have close friends that I connect with regularly Yes ☐ No ☐

Neuropsychological : (Beck's & Hamilton Inventory)

Social Emotional Issues: (Circle all that apply mark current with **C** or past with **P**)
Please include how long you have been feeling any that are Current.

Social anxiety	Rage	Insomnia Poor memory	Experiencing high stress levels
Fears	Shame		
Phobias	Grief	Difficulty concentrating	Frequently feel overwhelmed
Paranoia	Depression	Lose your temper easily	Anxiety and/or Panic attacks
Anxiety	Self-hatred Anger		
			Suicidal Thoughts

Do you take prescription medications for depression, anxiety or other psychological symptoms?

Ever considered or attempted suicide Yes ☐ No ☐ Year_________________________

Treatment for depression or other psychological issues Yes ☐ No ☐ Year___________________

Treatment for alcohol or drug addiction Yes ☐ No ☐ Year___________________
Other Treatments:

Major trauma:

Emotional trauma____

____

Physical, Concussion, Accidents____

____

Medical History:

Any Present Illness: Yes ☐ No ☐

1. Location of illness or complaint(s):

2. Severity/Quantity:

3. Duration (how long have you been experiencing this illness or complaint(s):

4. Associated Symptoms:

5. Modifying Factors – what makes it better or worse?

Have you ever been diagnosed with any of the conditions listed here? If so, who made the diagnosis? When?_ **Circle, highlight and or describe any that apply:**

Cancer	Diabetes
High Blood Pressure	Hepatitis
Thyroid disease	Seizures

Other (please list):
Surgeries (including cosmetic)

Hospitalizations? Provide date and reason for each

Allergies/Sensitivities: drugs/chemicals/foods

How were they diagnosed and/or treated?

List of all medications you have used in the past 6 months. Be sure to include prescription drugs, over-the-counter medications you have purchased yourself, herbs, vitamins and supplements. *(For contraindication reasoning please indicate the reason you took each, who recommended them, dosage and how long you used each one.) Attach Separate paper or put on the back of the last page if needed:

Family Medical History **Circle, highlight and or describe any health related subjects that apply:**
Has anyone in your immediate, biological family (parents, grandparents, siblings or children) ever been diagnosed with any of these conditions? Please circle and state which family member.

Cancer/Type

Diabetes	Heart disease
High Blood Pressure	Thyroid Disease

Mental Health Issues

Seizures

Alcoholism

Hepatitis

Other (please list)

Physical activity

Exercise? Yes ☐ No ☐ How often: __________________Type of exercise:________________________

Do you spend time outdoors? Yes ☐ No ☐ How often: __________________

Career & or Volunteer work: Describe your job/work: _______________________________________

____

How long have you had this occupation/position?

Do you enjoy your work?

How many hours a day are you in front of a computer/tablet/smartphone?

How would you rate your stress level? (1-10; 10 being over the top)

Sleep Habits

Hours of sleep each night:

Have you ever been diagnosed with insomnia?

Trouble falling or staying asleep?

Does your sleep schedule vary?

Do you use sleep medications? How often?

Do you have sleep apnea?

General Habits

Cigarettes: Do you currently smoke/vape?

How many cigarettes per day?

If you smoked in the past, how many years did you smoke? When did you quit?

Coffee: How many cups per day?

Tea: What kind? How much per day?

Alcohol: How much alcohol do you drink each day? Each week? Each month?

Has drinking alcohol ever caused problems in your life such as family issues, job loss, legal problems?

Recreational drugs: Are you currently using any kind of recreational drug?

Frequent marijuana user

Have you used them in the past?

What kind and how often?

Are you self-medicating? If so, with what

DIET:

Mediterranean Diet

Paleo

Vegetarian

Carnivore

Whole Foods

Mostly Organic

Other:_________________

How soon after you wake up do you eat or drink?

How much water do you drink each day?

Do you keep track of your water intake?

Is your appetite good or poor?

How long have you been at your current weight?

Any significant weight gain/loss in the past five years?

Have you ever been treated for an eating disorder?

Do you crave sugar?

If so, what kind of sweets do you enjoy?

Do you crave salt?

If so, what kind of salty foods do you enjoy?

Skin

Rashes (where?)

Excessively oily skin

Excessively dry skin

Hair loss

Dandruff

Other

Acne

Hives

Itching

Eczema

Psoriasis

Treatments/Products used:

Eyes, Nose, Throat Circle or highlight if applies

Glasses or contacts

Frequent ear infections

Glaucoma

Hearing loss

Cataracts

Hay fever

Night blindness

Migraine or other chronic headaches

Hearing aids

TMJ

Ringing in ears

Chronic dental problems (cavity/root canal/etc.)

Sinus problems (chronic congestion/infections)

Cardiovascular

High or low blood pressure

Arrhythmia (irregular heart rate)

Elevated cholesterol or triglyceride levels

Swelling in hands or feet

Poor circulation

Chest pain

Heart disease

Numbness (where?)

Heart palpitations

Pacemaker

Treatments:

Respiratory

Chronic cough

Bronchitis (frequency/treatment)

Frequent colds/respiratory infections

Pneumonia (frequency/treatment)

Asthma (onset/treatment)

Number of colds per year

Difficulty breathing

Number of sinus infections per year

Breathless with exertion

Lung disease (describe)

Treatments:

-

Urinary Tract

Bladder infections (current or in the past)

Wake up in the night to urinate

Cystitis

Blood in urine

Kidney infections

Kidney stones

Incontinence

Family history of kidney disease

Other:

Frequent urination

Treatments:

Gastrointestinal

Number of bowel movements per day:

Nausea

Gastric reflux

Gas

Heartburn

Belching

Irritable Bowel Syndrome

Indigestion

Diverticulitis

Bad breath (halitosis)

Crohn's disease

Bloating after meals

Gastric bypass or similar procedures

Chronic or frequent constipation

Diarrhea

Undigested food in stool

Hemorrhoids

Blood in stool

Pain or discomfort with bowel movements

Oral/Dental:

Mercury-based fillings

Gum disease

Root canal(s)

Excessive/insufficient saliva

Implants or posts

Mouth ulcers/Oral herpes

Men: Reproductive Health:

Prostate inflammation or swelling

Pain or difficulty urinating

Prostate cancer

Venereal disease

Infertility issues

Benign prostate hypertrophy

Impotence or erectile problems

If you are over 50 years of age: Do you have annual PSA screening? Last screening:

Women: General Reproductive Health: Date of last mammogram:____________ Date of last PAP:___

Age of first menstrual cycle_______

Cycle of menstrual period/days_______

Length of period________

PMS symptoms (please check all that apply)

Edema (swelling of hands or feet)

Food cravings

Mood swings

Insomnia

Headaches

Cramping

Bloating

Breast tenderness

Heavy menstrual flow/Blood clots

Irregular menstrual cycle

Skipped periods

Pain at ovulation (mid cycle pain)

Breakthrough bleeding

Fibroids/type?

Ovarian cysts/PCOD

Pelvic inflammatory disease

Sexually transmitted disease/type?

Herpes

Vaginal warts

Cervical dysplasia

Irregular PAP test/when?

Uterine cancer

Ovarian cancer

Breast lumps/cysts

Breast augmentation/reduction

Breast cancer

Breast pain

Treatments:

Pregnancy

Have you ever been pregnant?

Number of live births

Number of miscarriages

Infertility issues

Are you or could you be pregnant now?

Health issues during pregnancy?

Using birth control

Number of abortions

Perimenopausal/ Menopausal symptoms (please check or circle all that apply):

Are you having regular menstrual periods?

Headaches

Hot flashes

Heavy menstrual bleeding/flooding

Night sweats

Incontinence/frequent urination

Insomnia/sleep problems

Memory problems/Poor concentration

Weight gain

Mood swings

Lack of libido

Depression

Vaginal dryness

Fatigue

Currently using hormone replacement therapy?

bio-identical hormones

Date of last menstrual period:

Other:

Treatments:

Toxic Load:

Regular exposure to chemicals:_________________________ (specifically)

Heavy Exposure to WiFi

Home, work or school near WiFi tower

Exposure to mold

Heavy metal exposure

Use cleaning/laundry products that are not organic/non-toxic

Use make-up and or skin-care that is not organic

Deodorant with aluminum

Food storage:

Use aluminum foil

Use plastic wrap/Zip locks etc. often

Often wear clothing manmade fabrics

SAUNA USE

PLEASE CHECK ANY BOX THAT APPLIES TO YOU:

- Diagnosed with any medical condition, such as Anhidrosis, that may limit or prevent your ability to sweat?
- Do you have unstable angina?
- Have you had a recent heart attack?
- Do you have severe arterial disease?
- Clients using any medications must consult a physician or pharmacist prior to the use of the sauna.
- Pregnant women should consult their physician prior to the use of the sauna. Excessive body temperatures have a potential for causing fetal damage during the early days of pregnancy.
- For safety reasons, there is a weight limit of no more than 350 lbs. per person in order to utilize sauna.

DO ANY OF THE FOLLOWING APPLY TO YOU?

- **Any metal in the body** **Terahertz**
- Trauma to the feet (broken bones, open sores or wounds, osteoporosis) **Terahertz**
- Infections of the foot or contagious illness
- Diabetes
- Deep Vein Thrombosis
- Severe edema
- **High-Risk pregnancy or history of miscarriage**
- Constipation
- Blood Clotting Issues
- Head Aches

THOSE WHO SHOULD NOT DO IONIC FOOT SOAKS

- Suffer from Epilepsy OR Seizures Brain Entrainment
- Have a pace-maker or other electrical monitoring device
- Pregnant
- Open wound or cut on feet
- Organ Transplant
- Liver Disease
- On Blood Thinners
- Auto-Immune Disorder (use with caution)
- Diabetes (ok on lower frequencies or Frequency Detox

Musculoskeletal

- Chronic neck or back pain
- Low back pain
- Neck or shoulder tightness
- sprains/torn ligaments
- Back surgery
- Osteoarthritis

✓ Rheumatoid arthritis ✓ Osteoporosis

✓ Musculoskeletal Treatments:

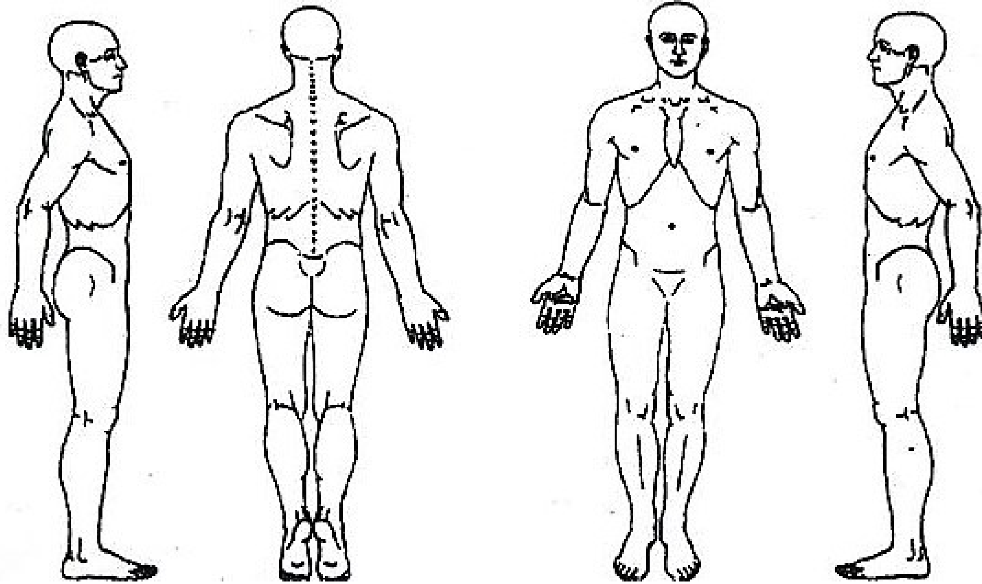
✓

✓

✓ **<u>Where is tension/pain most evident in your body</u>**

Shade in all areas of pain. Grade the intensity of pain in each area using 0 - 10 scale:

0 = no pain / no discomfort, 10 = the worst pain you can imagine



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