Holistic Bio Spa

# New Patient Information Form & Medical History.

# Please fill out all the pages and sign the first and last one.

***You will be given a lot of information from current, evidence-based medicine which will be new to you, and may even challenge your current believe systems.**

Patient Full Name_____ Date of Birth _____

Address: City_____ State_____

_____ Zip Code_____ Country_____

Phone_____ e-mail_____

Current Doctor / Primary Health Provider _____

Gender: __Male _Female Height_____ Weight _____

**AUTHORIZATION FOR MEDICAL CLEARANCE**

I hereby authorize my Doctor or health professional to provide an agent of **Holistic Bio Spa** any and all records related with my Medical History, services provided and/or treatments. I understand that the employees of **Holistic Bio Spa** will protect my privacy and this information will be handed to other professionals only if needed in order to be provided with health services. I further understand they will not disclosure this information unless it is previously authorized by myself in writing.

Signature:_____ Date: _____

**PERSONAL HISTORY**

Place of Birth_____ Current Residence_____ Have you lived outside your country for more than 6 months? If yes, explain _____

Marital Status_____ Religion_____

Do you practice on regular base any sport or physical activity? _____

_____

Do you live in contact with animals, insects, etc.? _____

_____

What is your current Occupation? _____

| *List usage of:* | *No* | *Yes* | *Quantity* | *Daily* | *Weekly* | *Occasionally* |
|---|---|---|---|---|---|---|
| *Tabaco* | ___ | ___ | _____ | ___ | ___ | ___ |
| *Alcohol* | ___ | ___ | _____ | ___ | ___ | ___ |
| *Caffeine* | ___ | ___ | _____ | ___ | ___ | ___ |
| *Marihuana* | ___ | ___ | _____ | ___ | ___ | ___ |
| *(Other)* | ___ | ___ | _____ | ___ | ___ | ___ |
| *(Other)* | ___ | ___ | _____ | ___ | ___ | ___ |



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**PERSONAL AND FAMILY MEDICAL HISTORY**

Please Check All that Apply

| *Disease or Condition* | *Personal* | *Family Member(s)* | *Describe* |
|---|---|---|---|
| Heart Attack | | | |
| Stroke | | | |
| High Blood Pressure | | | |
| Other Heart Disease | | | |
| Diabetes | | | |
| Obesity | | | |
| Cholesterol | | | |
| Thyroid Disease | | | |
| Disorders of Growth | | | |
| Disorders of Sexual Development | | | |
| Epilepsy / Seizures | | | |
| Dementia | | | |
| Anxiety / Depression | | | |
| Mental Disease | | | |
| Drug Abuse / Addictive Disorder | | | |
| Kidney Disease | | | |
| Kidney Stones | | | |
| Urinary Tract Infections | | | |
| Prostate Enlargement | | | |
| Severe allergies | | | |
| Immune Deficiency | | | |
| Arthritis / Lupus | | | |
| Gout | | | |
| Fibromyalgia / Chronic Fatigue | | | |
| Osteoporosis | | | |
| Esophagus Disorders | | | |
| Gastritis / Ulcers (stomach) | | | |
| Hiatal Hernia | | | |
| Colitis / Irritable Colon | | | |
| Chron or Celiac Disease | | | |
| Pancreas Disease | | | |
| Liver Disorders | | | |
| Hepatitis A, B or C | | | |
| Asthma | | | |
| Emphysema / Chronic Bronchitis | | | |
| Tuberculosis | | | |
| Anemia | | | |
| Thrombosis | | | |
| Uterine Cancer | | | |
| Breast Cancer | | | |
| Ovarian Cancer | | | |
| Prostate Cancer | | | |
| Stomach / Esophagus Cancer | | | |



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| | | | |
|---|---|---|---|
| Colon Cancer | | | |
| Bone Cancer | | | |
| Thyroid Cancer | | | |
| Leukemia | | | |
| Lung Cancer | | | |
| Skin Cancer | | | |
| Other | | | |
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**ALLERGIES**

Please Check All that Apply

| | | | |
|---|---|---|---|
| ___Penicillin | ___Morphine | ___Codeine | ___Sulfa |
| ___Aspirin | ___Nitrates | ___Allergy to Dyes | ___Seasonal (Pollen) |
| ___Food Allergies | ___Other Medicines | ___Chemical Products | ___Other |

Please Describe the Allergic Reaction that you Experience and when did this happen

**CURRENT PRESCRIPTION DRUGS**

| *Drug Name* | *Intensity* | *Start Date* | *Daily Doses* |
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**HORMONE ON USE (INCLUDDING ORAL CONTRACEPTIVE)**

| *Hormone Name* | *Intensity* | *Start Date* | *Daily Doses* |
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**OVER THE COUNTER MEDICINES**

Please Check all Products Used Occasional or Regularly

| | | | |
|---|---|---|---|
| ___Aspirin | ___Tylenol | ___Ibuprofen | ___Naproxen |
| ___Sleeping Aid | ___Laxative | ___Antiacids | ___Acid Blocker |
| ___Cough Suppressor | ___Anti-Histamine | ___Decongestant | ___Combination for Flu |
| ___Fiber | ___Stool Softeners | ___Antidiarrehal | ___Other |

Please List Other

**NUTRITIONAL SUPPLEMENTS**

Please Check all Products Used Occasional or Regularly

_____VITAMINS (Multiples like B-Complex or Individuals like Vitamin A, E, D)

_____MINERALS (Calcium, Magnesium, Chrome, etc.)

_____HERBALS (Examples: Ginseng, Gingko Biloba, Echinacea, Curcumin, Saw Palmetto, etc.)

_____SUPLEMENTS (Protein, Aminoacids, Fish Oil -Omegas-, Garlic, Glutamic Acid, etc.)

_____ENZYMES (Digestive Formulas, Papain, Bromelain, etc.)

_____OTHER (please list)

**GINECOLOGY HISTORY (WOMEN ONLY)**

Age of first Menstruation_____How many Pregnancies you had? _____



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Any Pregnancy Terminations? ____No ____Yes How many? _____

Have you had a Cesarean Cut? ____No ____Yes How many? _____

Have you had a Hysterectomy? ____No ____Yes Date _____

Were your ovaries removed? ____No ____Yes Date _____

Have you had a Tubal Ligation? ____No ____Yes Date _____

Have you had Premenstrual Syndrome? ____No ____Yes Describe _____

Have you had Fibrocystic Breasts? ____No ____Yes Describe _____

Did you Breastfeed your Childrens? ____No ____Yes Describe _____

Date of your last Period _____

How do you consider your menstruations? ____Normal ____Abnormal Describe _____

_____.

Have you ever had any of the following test?

Mamography ____No ____Yes Date _____

Pap Cytology ____No ____Yes Date _____

Colposcopy ____No ____Yes Date _____

VACCINES / IMMUNIZATION HISTORY

| | | | |
|---|---|---|---|
| ___Poliomyelitis / Sabin | ___D.P.T. | ___Tuberculosis | ___Measles |
| ___Mumps | ___Rubella | ___Hepatitis A | ___Hepatitis B |
| ___Typhoid | ___Chicken Pox | ___Pneumococcal | ___Meningococcal |
| ___Shingles / Zostavax | ___Influenza | ___Yellow Fever | ___Papilloma Virus |

Please List Other

**HOSPITAL ADDMISSIONS AND SURGICAL PROCEDURES**

Please list any event of Hospital Admission and all Surgical Procedures, and Complications.

| *Reason for Hospital Admission* | *Date (year)* | *Complication* |
|---|---|---|
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**HISTORY OF TRAUMA, ACCIDENTS AND FRACTURES**

Please List any Injury, Medical Care Received and Permanent Disability

| *Injury* | *Date (year)* | *Complication / Permanent Disability* |
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**CURRENT SYMPTOMS AND/ OR REASON FOR ASKING HORMONE REPLACE THERAPY**

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**PATIENT'S SYMPTOM AUTOEVALUATION**

Please Check if Apply

| *Symptom* | *Absent* | *Slight* | *Moderate* | *Severe* |
|---|---|---|---|---|
| General Discomfort | | | | |
| Stress / Anxiety | | | | |
| Fast Aging | | | | |
| Sweet Cravings | | | | |
| Salt Cravings | | | | |
| Need for Nicotine of Caffeine | | | | |
| Humor Changes | | | | |
| Irritability | | | | |
| Nervousness | | | | |
| Emotional Instability | | | | |
| Decreased Libido | | | | |
| Harder to Reach Climax / Orgasm | | | | |
| Decreased Vigor / Erectile Dysfunction | | | | |
| Decreased Muscle Mass / Strength | | | | |
| Fatigue in the Morning | | | | |
| Fatigue in the Afternoon | | | | |
| Headaches | | | | |
| Depression | | | | |
| Low Body Temperature (Cold) | | | | |
| Cold Extremities | | | | |
| Cold Sensitivity | | | | |
| Swelling of Ankles / Wrists | | | | |
| Puffy Eyes / Face | | | | |

**Cont.**

| *Symptom* | *Absent* | *Slight* | *Moderate* | *Severe* |
|---|---|---|---|---|
| Goiter | | | | |



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|---|---|---|---|---|
| Memory Lapses | | | | |
| Misty Thinking | | | | |
| Hot Flashes | | | | |
| Night Sweats | | | | |
| Sleep Disorder / Insomnia | | | | |
| Weight Gain - Waist | | | | |
| Weight Gain – Hip | | | | |
| Heart Palpitation | | | | |
| Fast Heartbeats | | | | |
| High Blood Pressure | | | | |
| Slow Pulse Rate | | | | |
| Low Blood Pressure | | | | |
| Low Blood Sugar | | | | |
| High Cholesterol | | | | |
| High Triglycerides | | | | |
| Fluid Retention | | | | |
| Dizziness / Vertigo | | | | |
| Increased Facial or Body Hair | | | | |
| Decreased Facial or Body Hair | | | | |
| Loss of Scalp Hair | | | | |
| Acne | | | | |
| Dry or Brittle Hair | | | | |
| Dry Skin | | | | |
| Thinning of Skin | | | | |
| Brittle and Rupturing Nail | | | | |
| Allergies | | | | |
| Sensitivity to Chemicals | | | | |
| Loss of Bone | | | | |
| Colic | | | | |
| Sensation in the Breasts | | | | |
| Infertility | | | | |
| Vaginal Dryness / Athropy | | | | |
| Vaginal Infection / Urinary Tract | | | | |
| Menstrual Cycle Changes | | | | |
| Intermenstrual Bleeding | | | | |
| Other | | | | |
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When did your symptoms marked in the previous list first appear? _____

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Please describe any change in your symptoms associated with changes on your hormonal replacement or dose (if apply): _____

Where did you receive the information to consider the Bio-Identical Hormone Replacement Therapy?

_____Doctor _____Other Patient _____Friend / Family _____Book / Magazine_____Internet_____Other

Describe _____

What are your Objectives with Bio-Identical Hormone Therapy?

Please Write any Doubt or Question About the Bio-Identical Hormone Replacement Therapy

**Do you have hemorrhoids?** ☐ YES ☐ NO **Do you have any rectal bleeding**? ☐ YES ☐ NO

**Have you had any type of rectal surgery?** (Please explain):

**Do you take diuretics/blood thinners?**

Do you have any of the following?

☐ Epilepsy ☐ Pace Maker ☐ Heart Problems ☐ Pregnant

**If you found us on the web, what Keywords did you use?_____**



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# PERMISSION & AUTHORIZATION FORM

## PLEASE READ BEFORE SIGNING:

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Holistic Bio Spa. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care.

Holistic Bio Spa is a medical center; therefore, your consulting doctor is responsible for your diagnostic/protocol. Consulting doctors listed on this website are not employees of Holistic Bio Spa.
I confirm that I will continue with the treatments recommended by my consultant, in order to improve my quality of life, and not for the "CURE" of any disease

I understand that this analysis involves testing that is a safe, non-invasive, and natural way of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

This document is binding even in the case of errors in the spelling of my name, inconsistencies with my signature, because I recognize and accept the purpose of this document that makes me sole responsible. My wishes cannot be undone or disputed by any family member or legal heir or entity, nobody can sue or take legal action against Holistic Bio Spa or its affiliates, sponsors, partners, etc.

I understand that this analysis is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of this analysis & testing or any natural health, nutritional or dietary programs recommended, but rather I understand that this is a means by which safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

If you are still experiencing any abdominal pain, discomfort, diarrhea, constipation, gas and bloating, blood or mucous in your stools, fever, or any persistent abdominal symptom after having done colon hydrotherapy, notify the Holistic Bio Spa, and see your physician right away.

I willfully indemnify and hold harmless Holistic Bio Spa, its directors, affiliates, subsidiaries, property owners, representatives, agents, staff and suppliers, from and against all liabilities, claims, expenses, damages and losses, including legal fees (on an indemnity basis), arising out of or in connection with the spa treatments, services and or facilities. I have read and understood and in agreement of the foregoing. This permission form applies to subsequent visits and consultations.

(If minor, signature of parent or guardian is required)

_____
**NAME**

_____ _____/_____/_____
**SIGNATURE** **DATE**



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