HEALTH INSIDE OUT

Health History Intake Form

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____ **Date**_____

City _____ **State** _____ **Zip Code** _____

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ Age____ **Sex:** ☐ Male ☐ Female

Occupation _____ **Marital Status:** ☐ Single ☐ Married ☐ Other

Emergency Contact: Name _____ **Relationship**_____

Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

Current Height _____ **Current Weight** _____ **Blood Type**_____

How did you hear about HIO?

_____

What brings you here?

_____

_____

_____

_____

List your desired healthcare **goals** or **concerns** according to **priority**

1._____

2._____

3._____

Stress Level: **0 1 2 3 4 5 6 7 8 9 10** **0= no stress 10 = very stressed**

Quality of Sleep: **0 1 2 3 4 5 6 7 8 9 10** **0= poor 10=good**

Health Conditions: (Circle all that apply to you)

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Raynaud's Syndrome	□ Anger/Irritability	□ Mood Swings	□ Memory Loss
□ Fibromyalgia	□ Asthma	□ Osteoporosis	□ Seizures
□ Headaches / Migraines	□ Lung disorder	□ Tuberculosis	□ Eczema

□ Other _____

Surgeries: (Circle all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia
□Breast Augmentation	□ Metal implants	□ Other _____	

Allergies: (Circle all that apply to you)

□ Mold	□ Seasonal	□ Milk or Lactose	□ Animal
□ Chemical _____	□ Sulfites	□ Wheat/Glutens	□ Other _____

Social History: (Circle all that apply to you)

Caffeine use:	□ occasional	□ often	□ never	
Drink Alcohol:	□ occasional	□ often	□ never	
Exercise:	□ occasional	□ often	□ never	
Drink Water:	□ <64 oz./day	□>64 oz./day	□ never	
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never	□ previous Smoker
Sleep:	□<8 hours/night	□ >=8 hours/night	□ Insomnia	

Other _____

Family History: (Circle all that apply)

Arthritis:	□ Parent	□ Sibling	Hypertension	□ Parent	□ Sibling
Cancer:	□ Parent	□ Sibling	Stroke	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling	Thyroid	□ Parent	□ Sibling
Heart Disease	□ Parent	□ Sibling	Other _____		

Dental History: (Circle yes or no) Metal Fillings Y N Root Canal Y N

Women ONLY (circle yes or no):

Are your periods regular? yes no
Are you pregnant? yes no
Do you plan in becoming pregnant anytime soon? yes no
Menopause? yes no

Please list all current medications being taken _____

_____

_____

_____

Review of Systems – (Check box if you have had trouble with any of the following)

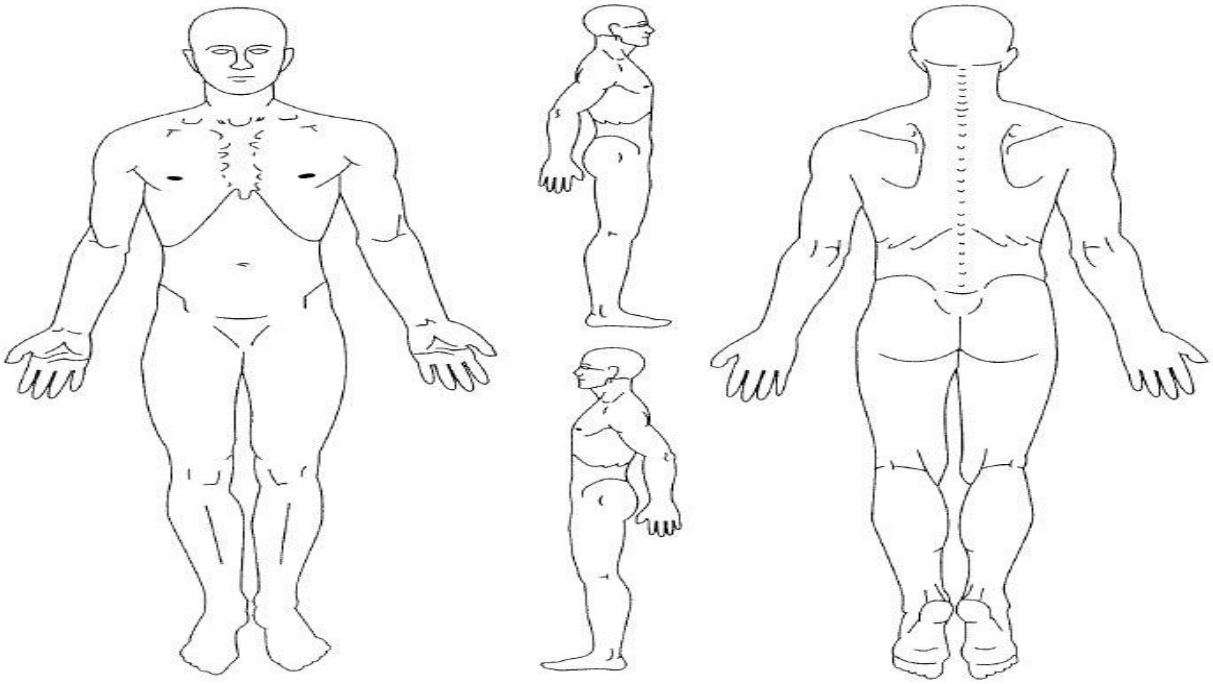
Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

(Office use only Notes:)

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

Last 24 hours:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain
Past week:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain

Does anything improve your pain? Yes No **If Yes, please list:**

When did your symptoms begin? _____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident
□ Other_____

How did your symptoms begin? _____
_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day)	□ Frequently (51-75% of the day)	□ Occasionally (26-50% of the day)	□ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

□ Sharp	□ Ache	□ Numb	□ Shooting
□ Burning	□ Tingling	□ Throbbing	□ Other _____

Diet and Nutrition: Check all that apply:

1. Are you on any special diet type? _____
2. Number of times you eat per day? _____
3. Amount of water/daily? _____ozs
4. Do you have a history of: compulsive or binge eating? ( ) eating disorder? ( )

5. What percentage of your meals consist of the following?
_____ Freshly home-cooked produce
_____ Restaurant meals
_____ Pre-cooked, microwave or TV dinners

6. What foods do you have an affinity for? ____sweet foods ____salty foods ____savory ____sour

7. Have you ever been tested for food allergies, or sensitivities? _____

8. Do you consume dairy or dairy by- products, and what kinds? If yet, how often during the week?

_____

9. Do you consume fast foods and soda beverages? _____

Lifestyle

On a scale of 1 to 10 (1= not very important, 5 = somewhat important, and 10 = very important)

a) How important is it for you to make lifestyle changes such as adjusting your diet, increasing your physical activity, and changing health-related behaviors? _____

b) How ready are you to make lifestyle changes? _____

c) How confident are you that you can make lifestyle changes? _____

1. What lifestyle changes would you be willing to make?

_____

_____

2. What things might make it hard for you to make lifestyle changes?

_____

_____

Physical Activity

1. Do you participate in regular physical activity?
   - o No. What form of exercise do you like to do? _____
   - o Yes. What type (s)? _____
   - How long? _____ How many times a week? _____

2. Do you practice mediation or other spiritual exercises?

_____

WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT

This waiver form covers services including Massage Therapy combined with Life-Coaching, as well as various wellness modalities such as Shockwave Therapy, PEMF Therapy, ARP Wave Therapy, White Light Therapy, Red Light Therapy, and other complementary therapies offered.

Terms of the Agreement:

1. Non-Medical Practitioner: I acknowledge that Angelo Alvarez of With Cryo, LLC ("Health Inside Out") is not a licensed medical doctor or healthcare provider. The services provided at Health Inside Out are for relaxation, wellness, and personal development purposes only and do not constitute medical treatment or advice.

2. No Medical Advice or Diagnosis: I understand that none of the services provided, including Massage Therapy and various therapeutic modalities, are intended to diagnose, treat, cure, or prevent any medical condition. Any advice given during sessions is for general well-being and personal empowerment, not medical advice.

3. Voluntary Participation: I confirm that I am voluntarily participating in these services, and I understand the nature of the techniques used. I have had the opportunity to ask questions about the procedures and fully understand the potential benefits and risks involved.

4. Responsibility for Health: I affirm that I am in good health or have consulted a healthcare professional before participating in these therapies. I take full responsibility for managing any pre-existing medical conditions and agree to inform Health Inside Out of any changes in my health status prior to each session.

5. Liability Waiver: I hereby release and discharge Health Inside Out, its employees, and agents from any claims, liabilities, or damages arising from my participation in the services, including but not limited to, personal injury, medical complications, or emotional distress.

6. Confidentiality: I acknowledge that any personal information shared during sessions will remain confidential and will not be disclosed to third parties without my express written consent, except where required by law.

7. Cancellations and Payment Policy: I agree to adhere to the cancellation and payment policies provided by Health Inside Out and understand that fees may apply for missed or canceled sessions without sufficient notice.

By signing below, I confirm that I have read, understand, and agree to the terms of this waiver. I acknowledge that I have the right to discontinue any session or treatment at any time and that participation is entirely voluntary.

Printed Name	Signature	Date

_____

Participant Parent or Legal Guardian Signature