PILOT HOLISTIC HEALTH

New Client Medical History

1. Client Details Date:

Last Name		First Name	Title
Date of Birth	Age	Biological Gender	
Occupation		Email	
Home Number		Cell Number	
Home Address			
			Zip
Work Address			
			Zip

2. Person Responsible for Account

Name(s)		Relationship
Address		
		Zip
Home #	Work #	Cell #

3. Referred by / How did you hear about the practice?

Names

The purpose of this questionnaire is to assist you in identifying the sources and causes of your health challenges. As such, it focuses on questions relating to any symptoms you may be experiencing, lifestyle, treatments and conditions you have been diagnosed for. Answer all questions as best as you can to assist us in helping you on your path towards restored and better health.

4. Current Medication & Supplements

Medicine	Daily dosage	Date started
Medicine	Daily dosage	Date started
Medicine	Daily dosage	Date started
Medicine	Daily dosage	Date started
Medicine	Daily dosage	Date started
Medicine	Daily dosage	Date started
Supplement	Daily dosage	Date started
Supplement	Daily dosage	Date started
Supplement	Daily dosage	Date started
Supplement	Daily dosage	Date started
Supplement	Daily dosage	Date started
Supplement	Daily dosage	Date started

List additional medications/supplements on the back page

5. Main Complaint(s)

a)	When did it start?
How often do you experience the symptom?	
What relieves and aggravates the condition?	
b)	When did it start?
How often do you experience the symptom?	
What relieves and aggravates the condition?	
c)	When did it start?
How often do you experience the symptom?	
What relieves and aggravates the condition?	
d)	When did it start?
How often do you experience the symptom?	
What relieves and aggravates the condition?	

If more space is needed please use the back

6. Medical History

Diagnosis	Date diagnosed	Current □ / Previous □
Diagnosis	Date diagnosed	Current □ / Previous □
Diagnosis	Date diagnosed	Current □ / Previous □
Diagnosis	Date diagnosed	Current □ / Previous □
Allergies:		

7. Surgical History

Surgery	Date performed
Surgery	Date performed
Surgery	Date performed

8. Family Medical History

Father
Mother
Grandfather (paternal)
Grandmother (paternal)
Grandfather (maternal)
Grandmother (maternal)
Siblings
Children

9. General Health

Energy levels (please rate): excellent □ good □ fair □ poor □	Lowest at _____ (time)
Sleep (please rate): excellent □ good □ fair □ poor □	Number of hours:
Appetite (please rate): good □ poor □	Number meals per day:

10. Diet & Digestive System

(Please provide details on your average daily diet)	
Breakfast	Time
Mid-morning snack	Time
Lunch	Time

Midafternoon snack	Time
Dinner	Time

(Please specify how often the following foods are consumed per week)			
Alcohol	Bread	Herbal tea	Cheese
Coffee	Fried foods	Fruit	Junk foods
Meat	Milk	Snack foods	Soft drinks
Sugar	Vegetables	Water	Wheat

Do you experience any of the following?		
Bloating	Nausea	Heartburn
Constipation	Diarrhea	Other

11. Additional Information

Do you experience any symptoms in the following areas?	
Menstrual Cycle	Details
Urinary Tract	Details
Sexual Function & Libido	Details
Dizziness	Details
Head	Details
Eyes	Details
Mouth	Details
Ears, Nose, Throat	Details
Chest	Details
Joints / Limbs	Details
Skin	Details
Stress Levels	Details
Other:	

12. Other

Pregnant	Yes	No
Nursing	Yes	No
Pacemaker	Yes	No
Organ Transplant	Yes	No

13. Health Goals

Which health concerns are most important for you at the moment?

14. Checklist

□ Fill out New Client Medical History form

□ Hydrate before appointment (especially important for live blood analysis)

□ **Bioenergetic Clients Only:** Stop taking any supplements 24-48 hours before appointment (DO NOT stop taking your prescribed medications)

□ **Bioenergetic Clients Only:** Bring any supplements or medications you are already taking or want to have tested. (prescriptions, multivitamins, pro-biotics, herbs, etc.)

□ Bring any other pertinent information not listed on this form (current lab or blood work results)

Consent and Indemnity

I _____ consent to have capillary blood drawn and my blood analyzed by the live blood analysis practitioner at this clinic.
I understand that the practitioner has received formal training in blood analysis and that all necessary infection control measures are followed as stipulated by the Department of Health.
I understand that live blood analysis and biofeedback is not a medical diagnostic procedure, that it does not replace the advice of a medical practitioner and that it is utilized as a nutritional assessment and education tool to assist with dietary and lifestyle recommendations.
I agree to stop taking any supplement, herb, tincture, or other nutritional aid that presents undesired results or interferes with any medication I am currently taking. It is my responsibility to check with a medical provider to confirm use of any supplement recommended.
I hereby indemnify, or hold harmless, the analyst against any claim regarding my analysis.
I agree to discuss options with the medical provider and consent to any procedure or regiment before treatment is received.

Signature of client/guardian: _____Date_____

Payment Agreement

I _____ consent to pay Pilot Holistic Health upon receipt of any service or supplement rendered. I understand that Pilot Holistic Health does not offer payment plans and does not accept insurance as payment.
I have read and agree to pay for each service rendered from the following price list:

Price list:
$100 Appointment with medical provider (Craig Howell, PA-C)
$250 Bioenergetic Analysis and Live Blood Analysis – Initial Appointment
$200 Bioenergetic Analysis – Initial Appointment
$150 Bioenergetic Analysis Appointment and Live Blood Analysis – Follow-up Appointment
$100 Bioenergetic Analysis – Follow-up Appointment
$85 Live Blood analysis

IV Nutritional Therapy: Prices Vary
Supplements: Prices Vary

$30 ABO Blood Typing, add on
$160 Aeroallergy Test, send off test
$10-15 Bioenergetic Energy Drops
$35 Candida Yeast Analysis, 15 minute appointment
$170 Environmental Test, send off test
$150 Hormone Panel, send off test
$200 Organic Acids Test, send off test
$20 Urine Analysis, add on
$230 96 Food Sensitivity Test, send off test
$290 144 Food Sensitivity Test, send off test
$350 208 Food Sensitivity Test, send off test

Signature of client/guardian: _____ Date_____