Medicine of Light

**Intake Questionnaire**

In order to be able to fully assist you, please fill out the following intake questionnaires to the best of your ability. There is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your chart, it is ok to refrain from putting it in this information. **Please be sure to sign and date the Complementary & Alternative Health Care Client Bill of Rights at the end. Thank you!**

PATIENT IDENTIFICATION

Name ___________________________________ First Appointment Date _____________________________

Address _________________________________ City _______________________ State _______ Zip ______

Home Phone # ________________________ Work # _______________________________________________

Birth Date ____________________________________________________ Age ________ Sex ___________

Religion ______________________________ Marital Status ________________________________________

Race _________________________________ Children ________________________________________________

Who are you currently living with? _________________________________________________________________

REFERRAL SOURCE___________________________________

MAIN PURPOSE OF THE CONSULTATION: Please give a brief summary of the main problems.

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WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What are your goals in being here?

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______________________________________________________________________________

______________________________________________________________________________

PRIOR ATTEMPTS TO CORRECT PROBLEMS: Please include contact with other professionals, medications, types of treatment, etc.

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______________________________________________________________________________

______________________________________________________________________________

MEDICAL HISTORY

Current medical problems/medications:_______________________________________________

______________________________________________________________________________

Current supplements/vitamins/herbs:_________________________________________________

______________________________________________________________________________

Past medical problems/medications: _________________________________________________

______________________________________________________________________________

Other doctors/clinics seen regularly: _________________________________________________

Any history of head trauma? (describe): ______________________________________________

Ever any seizures or seizure like activity? ____________________________________________

Prior hospitalizations, surgeries, scars (place, cause, date, outcome): ___________________________

______________________________________________________________________________

Any Dental problems? ___________________________________________________________

______________________________________________________________________________

Prior abnormal lab tests, X-rays, EEG, etc: ____________________________________________

Allergies/drug intolerances (describe): _______________________________________________

*Present Height* _________ *Present Weight* _________

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children) ________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Prenatal and birth events: Your parents attitudes toward their pregnancy with you ________________________

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc)
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Any birth problems, trauma, forceps or complications? _______________________________________________

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

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School History: Last grade completed ____________ Last school attended ______________________________

Average grades received _______________ Specific learning disabilities _______________________________

Learning strengths ______________________________________________________________________________

Any behavior problems in school? _________________________________________________________________

Employment History: (summarize jobs you've had, list most favorite and least favorite)

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Any work-related problems? _____________________________________________________________________

Military History? _______________________________________________________________________________

Ever Any Legal Problems? _______________________________________________________________________

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.
______________________________________________________________________________________

______________________________________________________________________________________

Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _______________________________________

Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) ____________________

Sexual history: (answer only as much as you feel comfortable)

Age at the time of first sexual experience: _______ Number of sexual partners: __________________________

Any history of sexually transmitted disease? _________ History of abortion? ____________________________

History of sexual abuse, molestation or rape? ______________________________________________________

Current sexual problems?______________________________________________________________________

Any history of being physically abused: __________________________________________________________

FAMILY HISTORY

Family Structure (who lives in your current household, please give relationship to each): ___________________

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______________________________________________________________________________________________

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Current Marital or Relationship Satisfaction_____________________________________________________

Significant Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)

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Natural Mother's History: Age_____ Occupation _________________ Highest grade completed _____________

Learning problems _____________________________________________________________________________

Behavior problems _____________________________________________________________________________

Marriages ____________________________________________________________________________________

Medical Problems ______________________________________________________________________________

Has mother ever sought psychiatric treatment? Yes ____ No_____ If yes, for what purpose? _________

Mother's alcohol/drug use history _______________________________________________________________

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

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Natural Father's History: Age_____ Occupation _________________ Highest grade completed ____________

Learning problems ___________________________________________________________________________

Behavior problems ___________________________________________________________________________

Marriages ___________________________________________________________________________________

Medical Problems ____________________________________________________________________________

Has father ever sought psychiatric treatment? Yes ____ No _____ If yes, for what purpose? ____________

Father's alcohol/drug use history ______________________________________________________________

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

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____________________________________________________________________________________________

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Siblings (names, ages, problems, strengths, relationship to patient) ____________________________________

____________________________________________________________________________________________

Children (names, ages, problems, strengths) _______________________________________________________

____________________________________________________________________________________________

**Brain Chemistry (check all that apply):**

____ Sensitive to emotional or physical pain; cry easily

____ Worry, anxiety, phobia, or panic

____ Difficulty getting to sleep or staying asleep

____ Difficulty with focus, attention deficits

____ Low energy, drive, and/or arousal

____ Obsessive thinking or behavior

____ Inability to relax after tension, stress

____ Depression, negativity

____ Lack self-confidence

____ Irritability, anger

____ Use alcohol or drugs or pharmaceuticals to improve mood

**Thyroid Function (check all that apply):**

____ Low energy

____ Easily chilled (especially hands and feet)

____ Other family members have thyroid problems

____ Can gain weight without overeating; hard to lose excess weight

____ Have to force yourself to do even moderate exercise

____ Find it hard to get going in the morning

____ Low blood pressure

____ Low body temperature (under 98 F)

____ Chronic headaches

____ Use food, caffeine, tobacco, and/or other stimulants to get going

**Hormonal Balance (women only - check all that apply):**

____ Premenstrual mood swings

____ Premenstrual or menopausal food cravings

____ Irregular periods

____ Experienced a miscarriage, and abortion, or infertility

____Use or have used birth control pills or other hormone medication, please specify: ______________________

____ Uncomfortable periods: cramps, lengthy or heavy bleeding, clots, sore breasts

____ Peri- or post-menopausal discomfort: hot flashes, sweats, insomnia or mental dullness

____ Skin eruptions (acne) with period

**Yeast Overgrowth (check all that apply):**

____ Often bloated, abdominal distention

____ Foggy-headed

____ Depressed

____ Yeast infections, itching in genital or rectal area

____ Used antibiotics extensively (over 2 weeks or repeatedly at any time in life)

____ Use cortisone or birth control pills for more than one year

____ Have chronic fungus on nails or skin or athlete's foot

____ Have dandruff

____ Recurring sinus or ear infections as an adult or child

____ Achy muscles and joints

____ Chronically fatigued

____ Stools unusual in color, shape, or consistency

**Adrenal Function (check all that apply):**

____ Difficulty getting up in the morning

____ Continuing fatigue not relieved by sleep

____ Craving for salt or salty foods

____ Increased effort to do every day tasks

____ Decreased sex drive

____ Increased time to recover from illness, injury or trauma

____ Light-headed or dizzy when standing up quickly

____ Mild depression

____ Increased PMS

____ Thoughts less focused, more fussy

____ Memory less accurate

____ Decreased tolerance for others or increased irritability

____ Don't really wake up until 10:00 AM

____ Afternoon low between 3:00 and 4:00 PM

____ Feel better after evening meal (after 6:00 PM)

Please describe below any other symptoms, issues, concerns that have not been covered in the questions above.

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**COMPLEMENTARY AND ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS**

**Practitioner: Karlie Cole**
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**www.medicine-of-light.com**
**E-mail: karlie@medicine-of-light.com**
**612-812-7127**

PATIENT INFORMATION

Patient's Name: ________________________________________________

Date of Birth: ______________ Age: ______ Sex: [ ] Male [ ] Female

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Home Address: ________________________________________________

Day Phone: (_____) ________________________ Occupation: ________________________

E-mail Address: ________________________________________________

Complementary and Alternative Health Care Title: Esogetic Colorpuncture Practitioner, Flower Essence Consultant

Qualifications: B.A. Sustainable Community Development, Prescott College, Prescott AZ, Certified Practitioner of Esogetic Colorpuncture, Herbal and Flower Essence Consultation

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, nurse, osteopath, physical therapist, dietician, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.

Supervisor of Practitioner: No supervisor.

Complaints: Any client may file a complaint with the Office of Complementary and Alternative Health Care, Health Occupations Program, Minnesota Department of Health, P.O. Box 64975, St. Paul, MN 55164-0975, 651-282-5623

Fees, etc.: Practitioner fees for unit of service are $50.00 per hour. Client pays long-distance and shipping & handling fees when needed. Payment is due by cash or check at the time the service is rendered. The fee is due if an appointment is missed without 24 hours notice. The Practitioner does not contract with any health maintenance organizations to provide service. The Practitioner does not accept Medicare, Medical Assistance, or General Assistance Medical Care. The Practitioner may accept partial payment or may waive payment. This must be discussed on an individual basis prior to the session.

Notice of Changes in Services or Charges: Clients have a right to reasonable notice of changes in service or charges.

Theoretical Approach: In general, the Practitioner's choice of modalities depends on your needs as a Client.

Right to information: Clients have a right to complete and current information concerning the practitioner's assessment and recommended service that is to be provided, include the expected duration of the service to be provided.

Treatment: Clients may expect courteous treatment and to be free from verbal, physical or sexual abuse by practitioner.

Client Records/Transactions: Client records and transactions with the practitioner are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law.

Access to Records: Clients have a right to be allowed access to records and written information from records in accordance with Minnesota Statute 144.335.

Other Services: Other services may be available in the community. Information concerning services is available by speaking with the practitioner.

Right to Choose, etc.: Clients have the right to choose freely among available practitioner and to change practitioners after services have begun.

Coordinated Transfer: Clients have the right to coordinated transfer when there will be a change in the provider of services.

Refusal of Services: Clients may refuse services or treatment, unless otherwise provided by law. Practitioner may refuse to serve any client, unless otherwise provide by law.

Assertion of Rights: Clients may assert their rights without retaliation.

Acknowledgment by Client

I hereby acknowledge receipt of the Client Bill of Rights and I have had full opportunity to ask any questions I have about this document and my rights as a client. I understand my rights as a client.

Client Signature ______________________________ Date ______________________________

Parent/Guardian______________________________ Date ______________________________

Legal Relationship to Client ________________________