Referred by:______________________ **Date**_____________

Confidential Intake Form

Name____ Nickname_______________________________

Address____

Email____ Cell/home phone___________________________

Date of Birth ________________ Place of Birth (city, state)____

Occupation ____

Marital Status _________ Name of Spouse/Significant Other __________________________ Number of Children______

Childhood Vaccines? **YES NO** Flu Shot? **YES NO** - Date of last flu shot: ____________

Any CV-19 Shot? **YES NO -** Date of last CV shot: ___________ Other vaccination: ___________Date:_______

CV Booster? **YES NO -** Date of last CV booster shot: ___________ Other vaccination: ___________Date:_______

***** If YES to any CV-19 shot, please note: with no long-term efficacy tests conducted, individual results may vary. *****

Have you ever taken antibiotics? **Yes No** Date last antibiotics taken?________________

Females: What was the date of your last menstrual period? ___________________ Are you pregnant? _________________

Please list prescription medications, over the counter, and natural supplements you are taking:_________________________

____

____

____

____

Health History

What brings you into the office?____

What is your biggest concern? ____

How long have you had health problems? ____

In the last year, what conditions have been treated by a medical doctor?______________________________________

____

____

____

What allopthatic diagnosis do you have? ____

What do you think may have caused/triggered the issues you are experiencing? ______________________________

____

When do you feel better and when do you feel worse? ____

What, if anything, seems to help? ____

Do you have any digestive difficulties? ____

Do you perspire a lot? **YES NO**

Any known allergies? **YES NO** Explain: ____

Any surgeries? ____

Lifestyle History

Do you drink alcohol? **YES NO** If yes, what type and amount per week? ____

Do you currently smoke or use tobacco? **YES NO** If yes, what type and amount per week? ____________________

Have you smoked or used tobacco in the past? **YES NO** What type? ____

For how long did you use? ___________________ When did you quit? ____

Do you use recreational drugs? **YES NO** If yes, what type and how often? ____

Do you exercise? **YES NO** Type and how often? ____

How much energy do you have? (1= lowest, 10 = highest) _________ Is this enough for you? ________________

How do you occupy free time? ____

How many hours per day do you perform the following? (number of times/hours plus D=daily or W=weekly)

Lifting _____ Sitting _____ Computer Use ____ Church/spiritual enrichment ______ TV _____ Family time_____

Do you sleep well? **YES NO** What time do you go to bed? ___________ Hours per night? ________

Wake up in the night/what time?_______________What position do you sleep in? _________________________

Do you take a sleep aid? **YES NO** If so, what?_________________________

How many bowel movements a day? _____ Describe (size, shape, form, etc.)_________________________________

Do you like or dislike hot/cold weather? ____

Do you feel stressed or depressed? **YES NO** If yes, from what? ____

____

What do you do, if anything, to help manage this stress? ____

Nutrition History

What beverages do you normally consume?

Coffee? **YES NO** Amount per day? ________________ Type: ________________________

Water? **YES NO** Amount per day? ________________ Type: ________________________ (Tap/Filtered/RO/Spring)

Soda/Juice? **YES NO** Amount per day? ________________ Type: ________________________

Milk? **YES NO** Amount per day? ____________________ Type: ________________________

Tea? **YES NO** Amount per day? ____________________ Type: ________________________

Sports Dinks? **YES NO** Amount per day? ____________________ Type: ________________________

What do you normally eat in a typical day?

Breakfast: ____

Lunch: ____

Dinner: ____

Snack/Desserts: ____

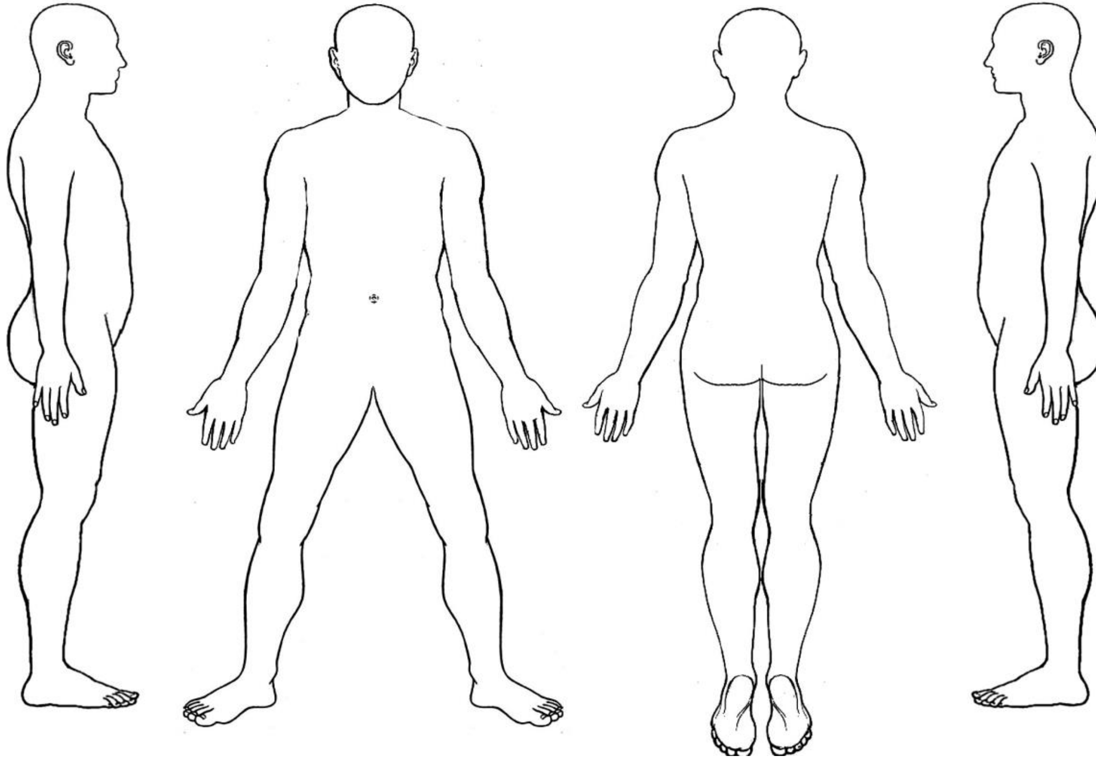
How often do you eat out? ____

Do you have food cravings? Sweet Salty Chocolate Breads Other ______________________________________

What type of salt do you use? ______________________________ How often? ____________________________

Please indicate on the body below where you are experiencing concerns

Place an "X" on the area(s) of concern on the body above,
and a number from 1 to 10 to indicate the level of severity.
(**1 being minor, 10 being major**)



Family History

If you are adopted, please fill out the following concerning your *biological* parents? If unable, mark N/A.

Is your father alive? If yes, how old? _____ If no, what was the cause of death and age at death?__________________

Is your mother alive? If yes, how old? _____ If no, what was the cause of death and age at death?_________________

In particular, does anyone have: (If yes, write "F" for father, "M" mother, "S" Sister, "B" Brother.)

______ Heart Disease ______ Lung Disease ______ Liver Disease ______ Kidney Disease

______ Cancer ______ Stroke ______ Diabetes ______ Asthma

______ Tuberculosis ______ Arthritis ______ Chronic Pain ______ Headaches

______ Scoliosis ______ Sleep Trouble ______ Mental Illness ______ Thyroid

______ Other: ____

Dental History

Past and present dental work performed Please list all. (i.e. root canal, mercury fillings, gum disease, surgery, etc.)

____

____

Any pain? **YES NO** If yes, please explain ____

Do you use fluoride toothpaste? **YES NO** Do you get fluoride cleanings? **YES NO**

Check the following conditions that apply now, mark with an X if in the past

Musculoskeletal

- ☐ Headaches
- ☐ Joint Stiffness/Swelling
- ☐ Spasms/Cramps
- ☐ Strains/Sprains
- ☐ Neck Pain
- ☐ Upper/Mid Back Pain
- ☐ Low Back Pain
- ☐ Shoulder, Neck, Arm, Hand Pain
- ☐ Hip, Leg, Foot Pain
- ☐ Chest/Rib Pain
- ☐ Numbness/Weakness
- ☐ Problems Walking
- ☐ Jaw Pain/TMJD
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or Joint Disease
- ☐ Other___________________

Circulatory/Respiratory

- ☐ Dizziness
- ☐ Shortness of Breath
- ☐ Fainting
- ☐ Cold Hands/Feet
- ☐ Cold Sweats
- ☐ Swollen Ankles
- ☐ Difficulty Lying Flat
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Heart Conditions/Chest Pain
- ☐ Palpitations
- ☐ Allergies
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Cough or Coughing Blood
- ☐ Wheezing
- ☐ Excessive Bleeding
- ☐ Pace Maker
- ☐ Lymphedema
- ☐ Other___________________

Skin

- ☐ Rashes
- ☐ Itching/Burning
- ☐ Hives
- ☐ Eczema
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Moles
- ☐ Acne, location _______________
- ☐ Rosacea
- ☐ Cosmetic Surgery
- ☐ Other______________________

Gastrointestinal

- ☐ Gum Bleeding
- ☐ Nervous Stomach
- ☐ Indigestion
- ☐ Heartburn/Reflux
- ☐ Nausea/Vomiting
- ☐ Change in Bowel Patterns/IBS
- ☐ Constipation
- ☐ Diarrhea
- ☐ Ulcers
- ☐ Abdominal Pain
- ☐ Gall Bladder Problems/Removal
- ☐ Diverticulitis
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Other_______________________

Nervous System/Eyes/ENT

- ☐ Numbness/Tingling
- ☐ Loss of Strength/Weakness
- ☐ Paralysis
- ☐ Twitching
- ☐ Chronic Pain
- ☐ Sleep Disorders
- ☐ Herpes/Shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy/Seizures
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Difficulty Hearing
- ☐ Ringing in the Ears
- ☐ Eye Correction
- ☐ Double Vision
- ☐ Cataracts
- ☐ Other_______________________

Reproductive/Urinary

- ☐ Burning on Urination
- ☐ Nighttime Urination
- ☐ Blood in Urine
- ☐ Erectile Dysfunction
- ☐ Prostate Problems
- ☐ Abnormal Discharge
- ☐ Yeast Infection
- ☐ Bladder Leakage
- ☐ Pregnancy
  - ☐ Current ☐ Previous
- ☐ PMS
- ☐ Menopause
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility Concerns
- ☐ Other________________________

Other

- ☐ Loss of Appetite
- ☐ Forgetfulness/Memory Loss
- ☐ Confusion
- ☐ Depression
- ☐ Anxiety
- ☐ Weight Loss/Weight Gain
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of Hair
- ☐ Hot/Cold Intolerance
- ☐ Difficulty Concentrating
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Eating Disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Infectious Disease
- ☐ Other _______________________

____

Blood Type ________

Height _______ Weight _________

Acknowledgment and Waiver of Liability Boro Holistic Health™

I, ___________________________, hereby certify and agree as follows:

I certify that I am seeking the consultation and treatment services of Boro Holistic Health™ as a Private Membership Association, for alternative healing suggestions and therapies, which I fully understand are not medical diagnoses or treatments or substitutes for medical diagnoses or treatments. I understand that I am responsible for all costs of care incurred in seeing any practitioner with Boro Holistic Health™. Any fees for professional services will be immediately due and payable. I understand and agree to allow Boro Holistic Health™ to use information in this form for the purpose of my wellness care and guidance towards a solution for my health concerns. Boro Holistic Health™ will only be using this health information for their rights concerning my health and the privacy of said information is safeguarded.

I certify that with respect to any medical conditions I may have, I will advise with my personal care physician, and understand that any physician with Boro Holistic Health™ is not a primary care physician. I understand that Boro Holistic Health™ does not handle medical conditions or emergencies and does not maintain hospital privileges. This practice specializes in a natural approach to healing the body using alternative healing modalities. I also understand that Dr. Suzanna Underwood is a Board Certified Doctor of Natural Medicine, not a medical doctor, and oversees all other staff members with said credentials.

In seeking to become a client of Boro Holistic Health™, I understand I am seeking analyses and/or therapies that are alternative in nature, therein not mandated by the FDA or offered by other physicians (allopathic or otherwise). These include, but are not limited to: Reams RBTI testing, Nutrition analyzing, Meridian Stress Analysis (Qest4 technology), Iridology, Reflex Analysis (kinesiology), Diagnostic Face-Tongue-Nail Reading, and Homeopathy.

I also agree that if I am taking psychiatric or other prescription medications, I am responsible for any and all modifications made to my prescription medications and will advise with my prescribing medical doctor as needed.

I understand and agree that Boro Holistic Health™ does not make any claims whatsoever, expressed or implied, regarding effects or outcomes of the analyses or therapies provided and shall not be liable for same. I certify that I seek the advice and treatment of Boro Holistic Health™ solely in my personal capacity, and I am not on this visit, or any subsequent visit, as an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

If I have an urgent question, I will call the Murfreesboro Clinic. If I feel it is an emergency, I understand that I need to call 911 or go to the nearest emergency room.

I understand and agree on behalf of myself, my dependents, heirs, administrators, legal representatives, and assigns, to release and hold harmless Boro Holistic Health™, practitioners, all associates, employees, agents and representatives thereof from any and all liability for illness, injuries, or death, and for any losses or damages relating thereto, however occurring, in relation to my consultation with and/or treatment by Boro Holistic Health™. Without limitation, I understand and agree Boro Holistic Health™, nor any practitioners, associates, employees, agents or representatives thereof, is liable for any direct, indirect, consequential, or incidental damage, injury, death, loss, delay, or inconvenience of any kind which may be occasioned by reason of any act or omission, including, without limitation, any willful or negligent act or failure to act, or breach of contract.

My signature below indicates that I have carefully read and reviewed this Acknowledgment and Waiver of Liability, and I fully understand all of its terms and conditions. I execute and deliver this Acknowledgment and Waiver of Liability freely and voluntarily and without duress or coercion and with full knowledge of the representations contained herein and the rights relinquished, surrendered, released and discharged hereunder.

I accept full responsibility for my health and voluntarily complete this Acknowledgment and Waiver of Liability.

____

Client's Signature | Client's Name (printed) | Date