Pilot Integrative Health, LLC

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?

☐ Family/Friend Referral	☐ Physician Referral
Name:	Name:
☐ Facebook/Other	☐ Holistic/Organic Supporting Facilities
☐ Internet Search	Name:
☐ Sign/Advertisement	☐ Other:

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.

Blood Type: (circle one) **A** **B** **AB** **O**

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 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 Symptomatic Issues

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. Additional Health Information

Pregnant	Yes	No
Nursing	Yes	No
Pacemaker	Yes	No
Organ Transplant	Yes	No
Cigarette Usage If Yes – What is the frequency of use?	Yes	No
Have you received the COVID Vaccine? If Yes – When did you receive the initial vaccination? -- Have you received any booster shots and if so, when were they administered?	Yes	No

Are there other vaccinations you have received that you have concerns about? If yes, please list vaccine type & date received.	Yes	No
Are you currently using contraception? If yes, what form and duration of use?	Yes	No

13. 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:
$250 Adult Initial Appointment (2 hours)
$200 Child Initial Appointment (1.5 hours)
$150 Adult Follow-up Appointment (1 hour)
$100 Child Follow-up Appointment (1 hour)
$85 Live Blood analysis
$10 Bioenergetic Energy Drops
$30 ABO Blood Typing, add on
$45 Rife Therapy, add on
$100 Rife Therapy Appointment (45 min – 1 hour)

Supplements: Prices Vary

Signature of client/guardian: _____ Date_____