

## **INFRARED BODY WRAP INTAKE FORM**

This form is completely confidential. Please submit by email, fax, mail, or in-person before your appointment. *To enter information, click on the gray box. Press "tab" or "click" to move to the next gray box. Save answers.* 

| PROFILE:   |                                    |  |  |  |  |
|--|------------------------------------|--|--|--|--|
| Name:  | Gender: M F Age:                   |  |  |  |  |
| Today's Date: / / (dd/mm/yyy                               | /) Date of Birth: / / (dd/mm/yyyy) |  |  |  |  |
| Address:   |                                    |  |  |  |  |
|  |                                    |  |  |  |  |
| Telephone: (Home)  | (Cell) (Work)                      |  |  |  |  |
| Email:   |                                    |  |  |  |  |
| Occupation:  | Employer:                          |  |  |  |  |
| How did you hear about us?                                 |                                    |  |  |  |  |
| Have you ever had an infrared body wrap session?           |                                    |  |  |  |  |
| Why have you chosen to have an infrared body wrap session? |                                    |  |  |  |  |
| May we give you appointment reminder calls?                | □ Y □ N (phone)                    |  |  |  |  |
| May we leave you phone messages?                           | Y N (phone) same as above          |  |  |  |  |
| Name of Medical Doctor / Family Physician:                 | Telephone:                         |  |  |  |  |
| EMERGENCY CONTACT:   |                                    |  |  |  |  |
| Name: Relationship:  |                                    |  |  |  |  |
| Telephone: (home)  | (cell) (work)                      |  |  |  |  |
|  |                                    |  |  |  |  |

| Please list all current medications (prescr | ription or over-the-counter) | ) and supplements (I | herbs, vitamins) |
|---|------------------------------|----------------------|------------------|
|   |                              |                      |                  |

| Name of Drug / Supplement   | Used For                          | Date Started        | Dose / Frequency    |  |  |
|---|-----------------------------------|---------------------|---------------------|--|--|
|   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
| List past prescription medications:   |                                   | -                   |                     |  |  |
|   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
| List any known allergies (include drug  | s food environmental chemical a   | nd etc.) and the re | action(s) from them |  |  |
|   | s, rood, environmental, enemieara |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
| Y = current N = never P =   | past                              |                     |                     |  |  |
| Good energy? Y N P Rate your energy level: /10 (10 = best)                      |                                   |                     |                     |  |  |
| Fatigue: Y N P Rate your stress level: Low Average High Unbearable              |                                   |                     |                     |  |  |
| How often do you exercise? What type of exercise?                               |                                   |                     |                     |  |  |
| How many hours of sleep per night? If waking up frequently, what is the reason? |                                   |                     |                     |  |  |
| How much water do you drink per day?  |                                   |                     |                     |  |  |
| Type of water that you drink?   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |
|   |                                   |                     |                     |  |  |

| Please record your diet for the last 3 days:   |                                      |                                   |       |  |  |  |
|--|--------------------------------------|-----------------------------------|-------|--|--|--|
|  | Day 1                                | Day 2                             | Day 3 |  |  |  |
| Breakfast  |                                      |                                   |       |  |  |  |
| Lunch  |                                      |                                   |       |  |  |  |
| Dinner   |                                      |                                   |       |  |  |  |
| How often do yo  | ou have a bowel movement?            | Do you use laxatives?             | Y N   |  |  |  |
| Do you tends to  | wards?                               | rrhea 🗌 both 🗌 other:             |       |  |  |  |
| What is the colo   | or of your stool?                    | Any undigested food in stool? 🗌 Y | □ N   |  |  |  |
| What is the shap   | pe of your stool? 🗌 Well-formed      | Ribbon-like Pellets Oth           | er:   |  |  |  |
| How many time  | s have you been treated with antil   | piotics? For what condition(s)?   |       |  |  |  |
| Have you ever u  | used probiotics or yogurt after anti | biotic use? 🗌 Y 🗌 N               |       |  |  |  |
|  |                                      |                                   |       |  |  |  |
| What is your greatest health concern?  |                                      |                                   |       |  |  |  |
| How does it limit you the most?  |                                      |                                   |       |  |  |  |
| How committed are you towards making valuable changes?   |                                      |                                   |       |  |  |  |
| Would you be interested visiting with Dr. Cutler in regards to your health concern(s)? Y N Maybe in the future |                                      |                                   |       |  |  |  |
| Is there any other information that you feel is important that has not been covered?                           |                                      |                                   |       |  |  |  |
|  |                                      |                                   |       |  |  |  |
|  |                                      |                                   |       |  |  |  |
|  |                                      |                                   |       |  |  |  |
|  |                                      |                                   |       |  |  |  |