CUTLER INTEGRATIVE MEDICINE

SERVICES 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/yyyy) 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? ☐ Y ☐ N When?

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 (prescription or over-the-counter) and supplements (herbs, vitamins)

Name of Drug / Supplement	Used For	Date Started	Dose / Frequency

List past prescription medications:

List any known allergies (include drugs, food, environmental, chemical and etc.) and the reaction(s) from them.

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 you have a bowel movement? Do you use laxatives? ☐ Y ☐ N

Do you tends towards? ☐ constipation ☐ diarrhea ☐ both ☐ other:

What is the color of your stool? Any undigested food in stool? ☐ Y ☐ N

What is the shape of your stool? ☐ Well-formed ☐ Ribbon-like ☐ Pellets ☐ Other:

How many times have you been treated with antibiotics? For what condition(s)?

Have you ever used probiotics or yogurt after antibiotic use? ☐ Y ☐ N

What is your greatest health concern?

How does it limit you the most?

How committed are you towards making valuable changes? ☐ Little ☐ Moderate ☐ Very

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?

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BioCharger Contraindications

No controlled tests or studies have been run on these populations, the below items need to be followed and observed:

- Individuals with cardiac pacemakers, insulin pumps, MUST sit at least 6 feet away from your BioCharger.
- Individuals that are known to have photosensibility (I.E. Photoconvulsive Response, Epilepsy) should NOT use your BioCharger.
- Women who are pregnant should NOT use your BioCharger.
- Children under the age of eighteen (18) years old MUST be supervised by a parent or guardian during a BioCharger session.
- Individuals with chemotherapy ports that are mental based should NOT use your BioCharger.
- Individuals with metal plating in their heads should NOT use your BioCharger.

I have read the above and confirm that I do not have any of the above contraindications.

_____ _____

Patient Signature Date