CONSTITUTIONAL HYDROTHERAPY INTAKE FORM

This form is completely confidential. Please submit by email, fax, mail, or in-person ***3 business days*** before your appointment.

PROFILE:

Name: ____ Gender: ☐ M ☐ F Age: ______

Today's Date: ______/______/______ (dd/mm/yyyy) Date of Birth: ______/______/______ (dd/mm/yyyy)

Address: ____

____

Telephone: (Home) ______-______-______ (Cell) ______-______-______ (Work) ______-______-______

Prefer Email Correspondence? ☐ Y ☐ N Email: ____

Occupation: ____________________________________ Employer: ____________________________________

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Children / Ages: ____

____

How did you hear about us? ____

Have you ever had a constitutional hydrotherapy session before? ☐ Y ☐ N If so, for: ___________________________

May we give you appointment reminder calls? ☐ Y ☐ N (phone) ______-______-______

May we leave you phone messages? ☐ Y ☐ N (phone) ______-______-______ ☐ same as above

EMERGENCY CONTACT:

Name:	Relationship:
Telephone: (Home) ______-______-______ (Cell) ______-______-______ (Work) _____-______-______	

MEDICAL CONTACTS:

Name of Medical Doctor / Family Physician:

Telephone: ______-______-______

Date of last blood work: Date of last annual / physical exam:

List any other health care providers (name, specialty, telephone):

MEDICAL HISTORY:

List your health concerns in order of importance to you:

1. ____

2. ____

3. ____

4. ____

5. ____

Has any health concern recently changed or become worse? ☐ Y ☐ N

____

____

____

What has your doctor (currently & previously) diagnosed you with?

____

____

____

____

____

____

____

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: ____

____

____

Possible *Contraindications* & *Considerations*:

I have an acute bladder infection: ☐ Y ☐ N

I have a cardiac disease: ☐ Y ☐ N

I have malignant hypertension: ☐ Y ☐ N

I have neuropathy: ☐ Y ☐ N

I have Raynaud's syndrome: ☐ Y ☐ N

I have a pacemaker or other electrical implant: ☐ Y ☐ N

I have a blood clot: ☐ Y ☐ N

I have a malignancy or metastatic cancer: ☐ Y ☐ N

I am actively bleeding (very heavy menstruation): ☐ Y ☐ N

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

____

____

Present Weight: ________

Weight one year ago: ________

Maximum weight and when: ________

Minimum weight (adult) and when: ________

Ideal weight: ________

Height: ________

Which of the following do you currently use?

Y = Current	N = Never	P = Past

Substance	Y	P	N	Per day	Type	Duration
Coffee	☐	☐	☐			
Soft Drinks (sodas)	☐	☐	☐			
Artificial Sweeteners	☐	☐	☐			
Tobacco	☐	☐	☐			
Alcohol	☐	☐	☐			
Recreational Drugs	☐	☐	☐			
Painkillers	☐	☐	☐			
Steroids	☐	☐	☐			
Laxatives	☐	☐	☐			
Analgesics	☐	☐	☐			
Antacids	☐	☐	☐			

List any traumas (mental, emotional, physical), injury, illness, surgery or hospitalizations:

Incident	Date	Long-term effects

Note when and why you have had each of the following:

X-Rays:			**MRI:**	
Ultrasounds:			**CAT Scans:**	
Tuberculosis Test:			**Last Dental Work:**	
HIV test:			**Last Eye Exam:**	

<u>FOR MALES (*if applicable*):</u>

Are you currently sexually active? ☐ Y ☐ N Have you been sexually active in the past? ☐ Y ☐ N
Do you use forms of contraception? ☐ Y ☐ N ☐ Sometimes Since: ___________________________
Do you have regular prostate exams? ☐ Y ☐ N Any prostate exams abnormal? ☐ Y ☐ N If yes, results: _______________________________________
Do you have difficulty urinating completely? ☐ Y ☐ N ____
How many times do you get up from your sleep to go to the bathroom at night? __________________________________
Do you have any sexual problems or concerns? ☐ Y ☐ N Explain: ____

FOR FEMALES (*if applicable*):

Are you pregnant? ☐ Y ☐ N ☐ Unknown Age at first period: _______________

Date of last menstrual period: _____________ Length of monthly cycle (days): ______ Length of bleeding (days): ______

Are you currently sexually active? ☐ Y ☐ N Have you been sexually active in the past? ☐ Y ☐ N

Do you use birth control? ☐ Y ☐ N ☐ Sometimes

Method: ____ Since: ____

Number of pregnancies: _________ Live births: _________ Miscarriages: _________ Abortions: _________

Date of last PAP test: ______________ Any irregular PAP test? ☐ Y ☐ N Results: _______________________________

Dexa (bone density) Scan results: ____

Mammography? ☐ Y ☐ N Results? __________ Do you perform self-breast exams monthly? ☐ Y ☐ N _________

Have you had any of the following concerning your breasts?

☐ Pain ☐ Lumps ☐ Infections ☐ Cysts ☐ Nipple discharge ☐ Other _______________

Do you experience PMS? ☐ Y ☐ N

If yes, what are your symptoms of PMS?

☐ Cravings ☐ Bloating ☐ Breast tenderness ☐ Mood changes ☐ Other: _______________________

Are you menopausal? ☐ Y ☐ N Age of last period: ____________

If yes, list any menopausal symptoms: ____

____

Use of hormones? ☐ Y ☐ N

Type and dosage of hormones: ____

Do you experience vaginal infections? ☐ Never ☐ Rarely ☐ Frequently

Do you experience bladder infections? ☐ Never ☐ Rarely ☐ Frequently

Do you have any sexual problems or concerns? ☐ Y ☐ N Explain: ____

____

CHILDHOOD ILLNESSES: (*check all that apply*)

☐ Chicken pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Rheumatic fever

☐ Scarlet fever ☐ Tuberculosis ☐ Pertussis ☐ Other: ____

Where are you in the birth order? ☐ First ☐ Last ☐ Middle ☐ Only

VACCINATIONS: (*check all that apply*)

☐ DPT (diptheria, pertussis, tetanus) ☐ HIB (haemophilus influenza B) ☐ Small pox ☐ Varicella (chicken pox)

☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Gardasil (HPV) ☐ Hepatitis A

☐ Hepatitis B ☐ Seasonal Flu shot ☐ Tetanus Booster ☐ RotaVirus

☐ Meningococcal ☐ Pneumococcal ☐ Unknown

Adverse reactions to any vaccines: ☐ Y ☐ N / If so, please explain ____

____

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

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

FAMILY HISTORY:

Please indicate if you or any of your immediate family has had any of the following conditions:

Condition	Family Member(s)	Condition	Family Member(s)
Alcoholism / Drug abuse		Epilepsy	
Allergies / Hayfever		Heart disease	
Arthritis		High blood pressure	
Asthma / Emphysema		Kidney disease	
Auto-immune disease		Liver disease	
Bleeding disorder		Mental illness	
Cancer		Overweight / Obesity	
Diabetes		Stroke	
Digestive disorder		Thyroid problems	
Eating disorder		Other:	

☐ I don't know my family medical history (please explain why):

DIET / DIGESTION / LIFESTYLE / ENVIRONMENTAL:

Please record your diet for the last 3 days:

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			

Do you have dietary restrictions (religious, vegetarian, vegan)? ☐ Y ☐ N ______________________________________

How much water in ***ounces*** do you drink per day? __________ Type of water: __________________________________

How much coffee do you drink per day? ____

How often do you have a bowel movement? ____

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: ________________________

Y = Current	N = Never	P = Past

Good energy? ☐ Y ☐ N Rate your energy level: _______/10 (10 = best)

Fatigue: ☐ Y ☐ N ☐ P

If you have fatigue, when in morning, afternoon, evening is it the worst: ____

If you have fatigue, can you do what you need to during the day? ☐ Y ☐ N

Rate your stress level: ☐ Low ☐ Average ☐ High ☐ Unbearable

Outlets/Activities to relieve stress: ____

____

How often do you exercise: ____

What type of exercise: ______________________ For how long: ______________________________

How many hours of sleep per night: ________ If waking up frequently, what is the reason: ________________

Nightmares: ☐ Y ☐ N ☐ P

Sleepwalk: ☐ Y ☐ N ☐ P

Wake Refreshed: ☐ Y ☐ N ☐ P

Must nap during the day: ☐ Y ☐ N ☐ P

Grind teeth: ☐ Y ☐ N ☐ P

Snore: ☐ Y ☐ N ☐ P

Enjoy job: ☐ Y ☐ N ☐ P

Hours worked per week: ___________________________

Highest education level: ____

Quality of significant relationship: ____

How do you spend your free time: ____

History of sexual, mental/emotional, physical abuse: ☐ Y ☐ N ________________________________

If so, at what age and by whom: ____

Active spiritual practice? ☐ Y ☐ N ☐ P

Spiritually satisfied? ☐ Y ☐ N ☐ P ☐ Not sure ____

If not active spiritually or spiritually satisfied, do you desire to explore and discover this area of health? ☐ 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 ☐ Don't Know

Human adipose tissue from U.S. residents has revealed 700 chemical contaminants that have not been chemically indentified while more than 80,000+ chemicals and toxins have been developed, distributed, and discarded into the environment over the past 50 years. The majority of them have not been tested for potential toxic effects in humans and some of these chemical contaminants are commonly found in the job, at home, in the outdoors, in our foods, in our air, in our water, and even in utero which contribute to human disease.*

It is never a question if you are toxic, but it is a question of HOW toxic?

Are you exposed to tobacco smoke? ☐ Y ☐ N

Are you frequently exposed to animals? ☐ Y ☐ N

Are you frequently exposed to environmental pollutants? ☐ Y ☐ N ☐ Unknown

Cutler Integrative Medicine tests for heavy toxic metals, food sensitivities, solvents, pesticides, PCBS, phthalates & etc..

Would you be interested in exploring your overall "toxic burden" with Dr. Cutler: ☐ Y ☐ N ☐ Maybe in the future

REVIEW OF SYMPTOMS:

Y = Current	N = Never	P = Past

SKIN								
Rash:	☐ Y	☐ N	☐ P		Color change:	☐ Y	☐ N	☐ P
Hives:	☐ Y	☐ N	☐ P		Lump:	☐ Y	☐ N	☐ P
Psoriasis / eczema	☐ Y	☐ N	☐ P		Itchy:	☐ Y	☐ N	☐ P
Dry:	☐ Y	☐ N	☐ P		Warts / moles:	☐ Y	☐ N	☐ P
Cancer:	☐ Y	☐ N	☐ P		Perspiration	☐ Y	☐ N	☐ P
HEAD								
Headache:	☐ Y	☐ N	☐ P		Migraine:	☐ Y	☐ N	☐ P
Dandruff:	☐ Y	☐ N	☐ P		Head injury:	☐ Y	☐ N	☐ P
Oily / dry hair:	☐ Y	☐ N	☐ P		Hair loss:	☐ Y	☐ N	☐ P
NOSE								
Frequent Colds:	☐ Y	☐ N	☐ P		Nosebleeds:	☐ Y	☐ N	☐ P
Congestion:	☐ Y	☐ N	☐ P		Post nasal drip:	☐ Y	☐ N	☐ P
Polyps:	☐ Y	☐ N	☐ P		Seasonal Allergies:	☐ Y	☐ N	☐ P
EYES								
Dry / Watery:	☐ Y	☐ N	☐ P		Blurry Vision:	☐ Y	☐ N	☐ P
Double Vision:	☐ Y	☐ N	☐ P		Cataracts:	☐ Y	☐ N	☐ P
Glaucoma:	☐ Y	☐ N	☐ P		Styes:	☐ Y	☐ N	☐ P
Strain:	☐ Y	☐ N	☐ P		Discharge:	☐ Y	☐ N	☐ P
Itchy:	☐ Y	☐ N	☐ P		Dark under eyelid	☐ Y	☐ N	☐ P
MOUTH / THROAT								
Canker sores:	☐ Y	☐ N	☐ P		Cold sores:	☐ Y	☐ N	☐ P
Sore throat:	☐ Y	☐ N	☐ P		Gum disease:	☐ Y	☐ N	☐ P

Dentures:	☐ Y	☐ N	☐ P		Cavities:	☐ Y	☐ N	☐ P
Loss of tastes:	☐ Y	☐ N	☐ P		Hoarsness:	☐ Y	☐ N	☐ P
NECK								
Stiffness:	☐ Y	☐ N	☐ P		Swollen glands:	☐ Y	☐ N	☐ P
Full movement:	☐ Y	☐ N	☐ P		Tension:	☐ Y	☐ N	☐ P
RESPIRATORY								
Cough:	☐ Y	☐ N	☐ P		Tuberculosis	☐ Y	☐ N	☐ P
Shortness of breath w/ exertion:	☐ Y	☐ N	☐ P		Bronchitis	☐ Y	☐ N	☐ P
Shortness of breath sitting:	☐ Y	☐ N	☐ P		Pneumonia:	☐ Y	☐ N	☐ P
Shortness of breath lying down:	☐ Y	☐ N	☐ P		Asthma	☐ Y	☐ N	☐ P
Wheezing:	☐ Y	☐ N	☐ P		Painful breathing	☐ Y	☐ N	☐ P
CARDIOVASCULAR								
High Blood Pressure:	☐ Y	☐ N	☐ P		Rheumatic Fever	☐ Y	☐ N	☐ P
Low Blood Pressure:	☐ Y	☐ N	☐ P		Murmurs	☐ Y	☐ N	☐ P
Arrhythmias:	☐ Y	☐ N	☐ P		Palpitations:	☐ Y	☐ N	☐ P
Edema:	☐ Y	☐ N	☐ P		Chest pain:	☐ Y	☐ N	☐ P
URINARY TRACT								
Incontinence:	☐ Y	☐ N	☐ P		Pain w/ urination	☐ Y	☐ N	☐ P
Frequent Infections:	☐ Y	☐ N	☐ P		Kidney Stones	☐ Y	☐ N	☐ P
Urgency	☐ Y	☐ N	☐ P		Discharge / blood	☐ Y	☐ N	☐ P
GASTROINTESTINAL								
Heartburn:	☐ Y	☐ N	☐ P		Parasites	☐ Y	☐ N	☐ P
Indigestion:	☐ Y	☐ N	☐ P		Blood in stool	☐ Y	☐ N	☐ P
Bloating:	☐ Y	☐ N	☐ P		Diarrhea	☐ Y	☐ N	☐ P
Nausea:	☐ Y	☐ N	☐ P		Constipation	☐ Y	☐ N	☐ P

Vomiting:	☐ Y	☐ N	☐ P		Liver disease:	☐ Y	☐ N	☐ P
Change in appetite:	☐ Y	☐ N	☐ P		Gall bladder disease	☐ Y	☐ N	☐ P
Pancreatitis:	☐ Y	☐ N	☐ P		Ulcer	☐ Y	☐ N	☐ P
MUSCULOSKELETAL								
Weakness:	☐ Y	☐ N	☐ P		Arthritis:	☐ Y	☐ N	☐ P
Stiffness:	☐ Y	☐ N	☐ P		Leg cramps:	☐ Y	☐ N	☐ P
Tremors:	☐ Y	☐ N	☐ P		Pain:	☐ Y	☐ N	☐ P
NERVOUS SYSTEM								
Paralysis:	☐ Y	☐ N	☐ P		Sciatica:	☐ Y	☐ N	☐ P
Tingling / numbness:	☐ Y	☐ N	☐ P		Carpal tunnel:	☐ Y	☐ N	☐ P
Seizures:	☐ Y	☐ N	☐ P		Fainting:	☐ Y	☐ N	☐ P
MENTAL / EMOTIONAL								
Depression:	☐ Y	☐ N	☐ P		Anger / Irritability	☐ Y	☐ N	☐ P
Suicidal:	☐ Y	☐ N	☐ P		High strung/ tense	☐ Y	☐ N	☐ P
Anxiety	☐ Y	☐ N	☐ P		Fear / Panic:	☐ Y	☐ N	☐ P
Eating disorder:	☐ Y	☐ N	☐ P		Psych hospitalization	☐ Y	☐ N	☐ P
PTSD	☐ Y	☐ N	☐ P		Brain Fog	☐ Y	☐ N	☐ P
MISCELLANEOUS								
Night Sweats:	☐ Y	☐ N	☐ P		Cold hands / feet	☐ Y	☐ N	☐ P
Spontaneous sweat	☐ Y	☐ N	☐ P		Phlegm	☐ Y	☐ N	☐ P
Easily awaken	☐ Y	☐ N	☐ P		Loss of voice	☐ Y	☐ N	☐ P
Foul breath	☐ Y	☐ N	☐ P		Thirsty	☐ Y	☐ N	☐ P
Bruise easily	☐ Y	☐ N	☐ P		Hemorrhoids	☐ Y	☐ N	☐ P
Excessive dreaming	☐ Y	☐ N	☐ P		Bitter tasting mouth	☐ Y	☐ N	☐ P
Brittle nail	☐ Y	☐ N	☐ P		Oversleep	☐ Y	☐ N	☐ P
Sigh easily	☐ Y	☐ N	☐ P		Ringing ears	☐ Y	☐ N	☐ P

What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health, and in adhering to the therapeutic protocols?

____

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____

What are your goals and expectations after your first new patient visit?

____

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____

Is there any other information that you feel is important that has not been covered?

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Thank you very much for taking the time to complete this thorough form.
It will greatly assist in the formulation of an individualized protocol specific to your healthcare needs

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- Onstot, J. et al., "Characterization of HRCG/MS unidentified peaks from the analysis of human adipose tissue." Vol 1. Technical Approach, US EPA Office of Toxic Substances (560/8-87-002a); 1987
- Second national report of human exposure to environmental chemicals. CDC. Washington DC. NCEH Pub. No. 03-0022, January 2003. www.cdc.gov/exposurereport