Colville Naturopathic Clinic P.S.

Biofeedback Intake Form (EPFX/SCIO)

Name:_____ Date_____

Physical Address: _____

City: _____ State: _____ County: _____ Zip: _____

Date of Birth: _____ Place of Birth: _____ O Female O Male

Blood Type (if known) _____ Contact Phone # _____

Number of organs removed		Personal Stress (scale of 1-10)	
Number of Synthetic Drugs used currently		Number of sugar products in a day	
Number of times Tobacco used in a day		Number of exercise sessions in a week	
Number of Steroid type drugs used in the past year		Number of alcoholic drinks in a day average	
Number of Amalgam (silver) fillings in your mouth		Number of Caffeine products per day (coffee, tea, soda)	
Number of recreational drugs used each month (legal or illegal)		Number of Toxic Exposures (radiation, chemicals, insecticides, etc.)	
Number of all known allergies		Number of major injuries in the past	
Number of unresolved emotional factors (anger, depression, anxiety, etc.)		Number of major infections in the past	
I am responsible for my body (scale of 1-10)		Number of glasses of water per day	
Amount of fat in diet (%)		How many pounds over weight	

Please check if you have or have had any of the following:

___AIDS/HIV
___Alcoholism
___Allergy Shots
___Anemia
___Anorexia
___Appendicitis
___Arthritis
___Asthma
___Bleeding Disorder
___Breast Lumps
___Bronchitis
___Bulimia
___Cancer
___Cataracts

___Chemical Dependency
___Chicken Pox
___Depression
___Diabetes
___Emphysema
___Epilepsy
___Fractures
___Glaucoma
___Goiter
___Gout
___Heart Disease
___Hepatitis
___Hernia
___Herniated Disc

___Herpes
___High Cholesterol
___Kidney Disease
___Liver Disease
___Measles
___Migraine Headaches
___Miscarriage
___Mononucleosis
___Multiple Sclerosis
___Osteoporosis
___Pacemaker
___Parkinson's Disease
___Pinched Nerve
___Pneumonia

___Polio
___Prostate Problems
___Psychiatric Care
___Rheumatoid Arthritis
___Rheumatoid Fever
___Scarlet Fever
___Stroke
___Thyroid Problems
___Tonsillitis
___Tuberculosis
___Tumor Growths
___Ulcers
___Other_____
_____

Over →

Family History: Please indicate if any biological family members have had any of the following medical problems and if so who?

___Diabetes _____

___Hypertension _____

___Stroke _____

___Alcohol Problems_____

___Mental/Emotional Issues _____

___Heart Disease _____

___Hepatitis/Liver Disease _____

___Cancer _____

___ Congenital Problems _____

___Other _____

Please describe any concerns you have regarding your health, and what your health goals are.

_____

_____

_____

_____

_____
Signature

_____
Date

Over →