DharmaGaia Integrative Medicine
Empowering the Healing Process!

Name: _____

Address: _____ City_____State____ Zip _____

Age: _____ Height: _____ Weight: _____

Home/ cellular phone number: _____ Email: _____

Date/Place of Birth: _____ SSN: _____

Occupation:_____Marital Status: _____

In Emergency Notify: _____

Referred by: _____

Family Physician: _____

Date: _____May we have your permission to email information about topics that may interest you? Yes____ No____

The information below will help me to address your issues in a complete and timely manner. Please feel free to be absolutely honest, your answers are part of your confidential medical record. Use the back of the page if necessary.

MAIN PROBLEM OR GOALS(S) YOU WOULD LIKE TO ADDRESS:

1._____

2._____

3._____

4._____

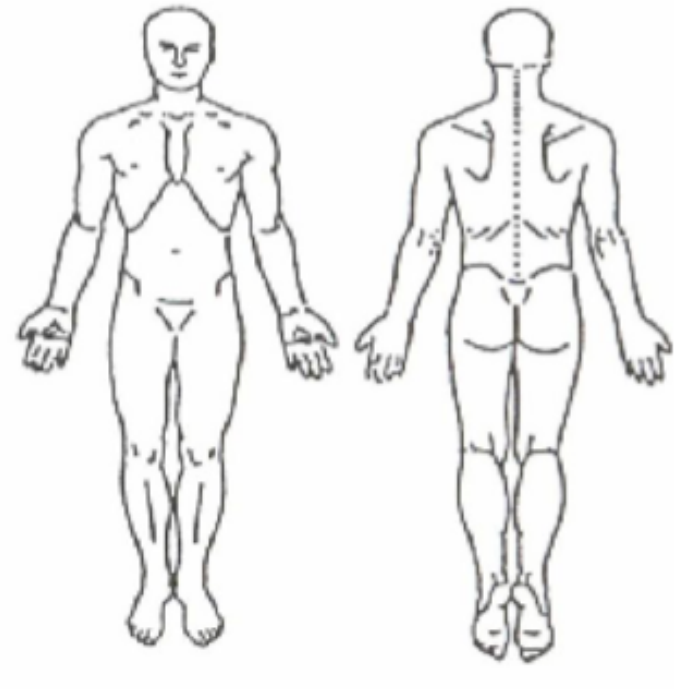
5._____

How long has it been since you first noticed this symptoms? _____

Do they stop? _____What kinds of treatment have you tried? Please include prescription medications, OTC, supplements. Indicate whether mg or UI (the quantity) and the form (calcium carbonate vs. calcium lactate). If you need more space please use a separate sheet.

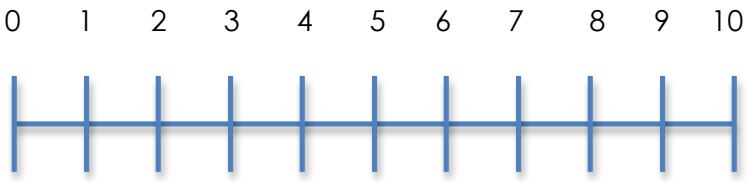
_____

If is difficult for you to pinpoint the exact area of pain, please use this graphic to circle the area:



Please use this to rate your issue, for example. If you have more than one, please rate them all below and use the back of the page if necessary.

Condition 1:



None Mild Moderate Severe Unbearable

Condition 2: _____

Condition 3: _____

Condition 4: _____

Condition 5: _____

To what extent does this problem affect your daily activities (work, sleeping, eating, etc.)? Please use the same scale to rate:_____

Are you taking any medications? (If yes, please describe) _____

_____

Do you have any allergies? (If yes, please describe) _____

_____

Do you smoke? ____ How many packages per day?_____

Do you drink alcohol? _____ How often?_____

Do you use any drugs?_____

How many cups of coffee do you drink per day?_____

Is there any history of cancer, diabetes, genetic disease or any other important illness in your family?_____

_____

_____

Please fill out the date and results if you have had any of these:

Colonoscopy: _____

CT/MRI: _____

Mammogram: _____

DEXA Scan (bone density): _____

Pap Smear for women PSA prostate exam for men: _____

_____

Heart Tests: _____

Any other: _____

_____

_____

What type of work do you do?_____

Do you enjoy your work?_____

How much stress do you feel at work? (Explain the source of stress)_____

_____

_____

_____

Do you experience the stress in any particular part of your body? _____

_____

_____

_____

Bed/sleep patterns (Please explain wake up time, bed time, how many hours of sleep do you usually need or get, irregular pattern, do you sleep well? Feel rested after you wake up)?: _____

_____

_____

PAST MEDICAL HISTORY (PLEASE INCLUE DATES):

☐ Allergies: _____ ☐ Cancer: _____

☐ Diabetes: _____ ☐ Hepatitis: _____

☐ High blood Pressure: _____ ☐ Heart disease: _____

☐ Seizures: _____ ☐ Rheumatic Fever: _____

☐ Venereal Disease: _____ ☐ Thyroid disease: _____

☐ Surgeries: _____

☐Other significant illness: (Describe): _____

_____

☐ Accidents or significant trauma/ fractures (describe): _____

_____

_____

OTHER RELEVANT MEDICAL HISTORY: _____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE PUT A CHECK NEXT TO CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION:

GENERAL:

☐ Poor appetite _____ ☐ Insomnia _____ ☐Disturbed sleep _____

☐ Localized weakness_____ ☐ Cravings _____ ☐ Strong thirst _____

☐ Weight gain _____ ☐ Weight loss _____ ☐ changes in appetite _____

☐ Sweating easily _____ ☐ Tremors _____ ☐ Bleeding or bruising_____

☐ Night Sweats _____ ☐ Fever _____ ☐ Chills _____

☐ Sudden energy drop (time of the day)? _____ ☐ Poor Balance _____

Other unusual or abnormal conditions you have noticed in your general sense of health? _____

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SKIN AND HAIR

☐ Rashes _____ ☐ Ulcerations_____ ☐ Hives _____

☐ Itching _____ ☐ Eczema _____ ☐ Pimples _____

☐ Dandruff _____ ☐ Hair loss _____ ☐ Recent moles _____

☐ Changes in hair or skin texture _____

Any other hair skin problems ? _____

HEAD, EYES, NOSE, THROAT

☐ Dizziness _____ ☐Concussions_____ ☐Migraines _____

☐ Glasses _____ ☐ Spots in front of eyes _____

☐ Eye pain _____ ☐ Poor vision _____ ☐ Night Blindness _____

☐ Color Blindness _____ ☐ Cataracts _____ ☐ Blurry Vision _____

☐ Earaches _____ ☐ Ringing in ears _____

☐ Poor hearing _____ ☐ Eyestrain_____ ☐ Sinus problems _____

☐ Recurrent sore throat _____ ☐Nose bleeds_____ ☐ Grinding teeth _____

☐ Sores on lips or tongue_____ ☐ Facial Pain _____ ☐ Teeth problem _____

☐ Headaches (where? When?) _____

☐ Jaw clicks_____ _____ ☐ TMJ _____

Any other head or neck problems?_____

CARDIOVASCULAR

☐ Dizziness _____ ☐ Low blood pressure_____ ☐Migraines _____

☐ Irregular heartbeat _____ ☐ High blood pressure _____☐ Fainting _____

☐ Cold hands or feet _____ ☐ Swelling of hands _____ ☐ Swelling of feet ___

☐ Blood clots _____ ☐ Difficulty in breathing_____ ☐ Phlebitis _____

☐ Chest pain: _____ ☐ Chest Pressure: _____

☐ Palpitations: _____ ☐ Varicose veins: _____

Any other heart-blood vessel problems?_____

RESPIRATORY

☐ Cough _____ ☐ Coughing out blood _____ ☐Asthma _____

☐ Bronchitis _____ ☐ Pain with deep inhalation ____ ☐ Pneumonia _____

☐ Cold hands or feet _____ ☐ Swelling of hands _____ ☐ Swelling of feet_

☐ Difficulty breathing when lying down _____ ☐ Phlegm (color?) _____

Any other lung problems?_____

GASTROINTESTINAL

☐ Nausea _____ ☐ Vomiting _____ ☐Diarrhea _____

☐ Constipation _____ ☐ Gas _____ Bowel Habit?_____

☐ Black Stools _____ ☐ Blood in stools _____ ☐ Indigestion _____

☐ Bad Breath _____ ☐ Rectal Pain _____ ☐ Hemorrhoids _____

☐ Abdominal pain or cramps _____ ☐ Chronic Laxative use_____

Any other problems with stomach or intestines?_____

GENITOURINARY

☐ Pain on urination_____ ☐ Frequent urination_____ ☐ Blood in urine _____

☐ Urgency to urinate_____ ☐ Unable to hold urine _____☐ Kidney Stones _____

☐ Decrease in flow_____ ☐ Impotence _____ ☐ sores on genitals ___

Do you wake up at night to urinate? _____If so, how often?_____

Any other urinary problems?_____

REPRODUCTIVE AND GYNECOLOGIC

☐ Menstrual Clots _____ ☐Painful menses_____ ☐Unusual menses _____

☐ Changes in body/psyche prior to menstruation_____ (Heavy or light) _____

☐ Irregular menses_____ ☐ Menopause (age)?_____ ☐ Hot flashes _____

Age at first menses_____Number of pregnancies_____Premature births_____

Miscarriages_____Abortions_____Number of births_____ LMP_____

Do you use birth control?_____If so, what type?_____For how long?_____

Hysterectomy or vasectomy, if applicable:_____

How is your sexual life? _____

Do you have any problems with sexual performance/Desire? _____

Can you achieve orgasm? _____

Discharge from penis or vagina: _____

Ejaculation problem: _____

Genital pain: _____Poor libido: _____

Vaginal dryness: _____ Pain with intercourse: _____

Are you sexually active? _____ Heterosexual ____ Homosexual _____ Bisexual ____

Have you ever had a sexually transmitted disease?_____ Please specify: _____

MUSCULOSKELETAL

☐ Neck Pain_____ ☐ Muscle Pains _____ ☐ Knee pain _____

☐ Back Pain _____ ☐Muscle weakness_____ ☐ Foot/ankle pains _____

☐ Hand/wrist pains _____ ☐ Shoulder pains _____☐ Hip pain _____

Any other joint or bone problems?_____

ENDOCRINE

☐ Thyroid problems: _____ ☐ Weight Loss/gain: _____

☐ Excess facial/body hair_____ ☐ Difficulty Swallowing_____

NEUROPSYCHOLOGICAL

☐ Seizures _____ ☐ Dizziness _____ ☐Loss of balance _____

☐ Areas of numbness _____ ☐Poor memory_____ ☐ Lack of coordination _____

☐ Concussion _____ ☐ Depression _____ ☐ Anxiety _____

☐ Bad Temper _____ ☐ Easily susceptible to stress _____

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological problems?_____

What is the emotion that commonly overcomes you? _____

How often do you exercise? _____What type of exercise? _____

Do you practice yoga? _____ How often? _____ What type?_____

Have you seen an holistic practitioner before?_____

Do you know your ayurvedic type?_____

Tell me a little about your diet. Do you eat organic? Meat? Dairy? Vegetarian?

Please describe what you usually eat in a regular day: _____

_____

_____

_____

What type of food do you crave for? (sweets, bread, spicy, etc) _____

_____

Do you have a spiritual or religious practice? _____ If yes,

describe:_____

What brings meaning or purpose to your life? _____

_____

Do you believe in past lives/Reincarnation?_____

Do you suffer from character shifts or mood swings?_____

Sudden onset of anxiety or depression?_____

Sudden onset of physical problems with no obvious cause?_____

Do you hear a voice(s) talking to you inside your head? _____

Do you have impulsive behavior? _____

Do you have memory problems? _____

Do you have poor concentration? _____

Is there any traumatic event you would like to share with me? Perhaps something related or that may have contributed to your current condition?_____

_____

_____

Would you be interested in having a kabalistic planetary analysis?_____
Would you be interested in receiving Harmonyum (energy healing)?_____

Relationship status: (Single, married, divorced, etc) _____
How do you feel about your current relationship status?_____

_____

_____

Do you feel spiritually and personally fulfilled at this moment? _____
What could be different?_____

_____

Do you have pets? ____ If yes, please describe names and type. How long have you have it?_____

Is there any forgiveness pending from your part? To somebody else or yourself?

_____

_____

_____

_____

_____

Environmental Exposures (check all that apply)

Regular exposure to second-hand smoke:
Mercury/silver amalgam fillings
Bleeding gums
Artificial joints or implants
Do you feel worse during a particular season?
Exposed to toxic metals or substances?
Reaction to flu shot?
Reaction to pneumonia shot?
Industrial pollution where you did grow up?
How often have you taken antibiotics?

COMMENTS

Please use this page to elaborate any of the above questions, to use a number from 1-10 (10 strongest) to quantify the impact or magnitude of the problem you are facing right now and to tell me of any other problems you would like to discuss:

I, the undersigned (client), do hereby affirm that I fully understand and agree to the following declarations:

1. Dr. Maria Manzanares, MD, does not offer or provide standard allopathic medical services, prescription drugs, surgery, chemical stimulants, radiation therapy, or any other conventional treatments; and all services she provides are strictly assessment, consultative, nutritional, observational and behavioral, using Integrative Medicine therapies, psychological origins of disease and other energetic healing and stress reduction techniques. These services are considered complementary alternative therapies and bio psychosocial techniques and don't require licensing by the States of California and Florida. Dr Manzanares is licensed Medical doctor and a certified Reiki master, Harmonyum practitioner, Akashic Records consultant and Naam Yoga therapist. She has been extensively studying the benefits of these alternative therapies since 2006 and continues to study to keep offering the most effective and updated complementary options to enhance self-healing. Many of these services may not be recognized as standard medical practice, generally accepted by the medical community, or approved by the Food and Drug Administration or other regulatory agencies. While many of these approaches have long been practiced, they may still be considered investigational or experimental. I am seeking care form Dr. Manzanares in order to benefit from her special training in integrative medicine and receive advice and treatment about such care. *Mind/Body Medicine*: Mind/body medicine is an emerging medical view intended to improve patient well being by improving lifestyle, capacity to function in a meaningful and effective way, and reversing the impacts of stress. Because stress and emotional states may play an important role in my medical conditions, Dr. Manzanares may assist me in recognizing more successful approaches to lifestyle and mind/body approaches such as meditation, massage, or other stress management techniques.

Energy Medicine: Energy medicine is a controversial approach to healing that has a long traditional history across many cultures, and for which there is some evidence can have a healing benefit. It is a hands off approach intended to balance the flow of energy in the body.

2. *Nutritional and Herbal Guidance*: Consultations may include discussion of diet, dietary supplements, and herbal or botanical products. While herbs and botanical products are generally available over-the-counter and considered safe based upon their long history of use, many of them have not been widely tested. There is some risk that these products could prove harmful, particularly if I am allergic to them, which in rare circumstances could lead to serious consequences. I understand that interactions between herbs, and between herbs and drugs, are not yet well known. While unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for high blood pressure or blood sugar. I will let Dr. Manzanares and other physicians know what herbs I am taking. And I agree to notify Dr. Manzanares if I experience any interactions or adverse experiences or reactions; if they are not serious I will notify her to ask for her assistance and if serious, I agree to seek emergency care first before notifying Dr. Manzanares.

3. Dr. Manzanares, does not recommend that I go against my (or any) medical doctor's orders and recommends that I continue my relationship with my regular physician if I consider it necessary. I understand that Dr. Manzanares, M.D. is not acting as my primary care physician. I understand that even though she may address issues affecting my general health, the practice is focused on a complementary, holistic or integrative approach to medicine. It is in my best interest to also have a primary care physician to ensure that I am fully informed

about all available conventional means to address any medical conditions I may have. This is also important because Dr. Manzanares' practice is exclusively office-based and is not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that Dr. Manzanares does not provide emergency, on-call assistance. Even should Dr. Manzanares provide treatment for a condition, I understand this assistance does not mean she is taking primary responsibility for managing that condition, but is complementing the care I receive from my primary care physician. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children.
I also understand that it is my responsibility on an ongoing basis to inform Dr. Manzanares of the name of and contact information for my primary care physician and treating specialists, of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions. I also understand that it is important for me to let my primary care physician know about any recommendations/treatments performed by Dr. Manzanares, in order to ensure that my care is properly coordinated.

4. Dr. Manzanares, cannot make predictions or promises as to the outcome of the sessions, other than she will give me her devoted best effort(s) and recommendations based upon a combination of her clinical experience and her knowledge.

4. I understand that the main person responsible for my own healing and the one who decides to follow any given recommendations is myself. I have read and understand the nature of the services provided by Dr. Manzanares. I represent that I am seeking treatment in order to further my own health and for no other

reason. I agree to take a responsible role in improving my own health and discuss advice and suggestions of Dr. Manzanares as presented in a treatment plan. I acknowledge that if I do not follow the treatment plan as provided, I may not receive the full benefit of the treatments proposed by Dr. Manzanares and I accept responsibility for less than satisfactory results. I am aware that I may withdraw this consent and discontinue following the recommendations at any time.

5. By signing this informed consent I agree to forever release Dr. Maria Manzanares, MD and/or Dharmagaia Health Care, from any and all actions, claims or demands that I, my heirs, next of kin, spouse and legal representatives now have, or may have in the future related in my participation of an Integrative Medicine consultation. I agree to be responsible for all legal costs and fees that may result from any action(s) on my part or on the part of my representative(s) against Dr. Manzanares and/or Dharmagaia Health Care.

6. I understand that Dr. Manzanares does not participate in any insurance plans. I understand and agree that Dr. Manzanares does not take assignment, which means that payment will be required at each visit. I understand that it will be my responsibility to submit claims to my insurer. I understand and agree that I am responsible for all charges incurred for all treatment rendered, including procedures and laboratory tests, even if my insurance company determines that any services are non-covered or excluded, or, in their opinion, are unreasonable or not medically necessary. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Dr. Manzanares to take action to secure payment of an outstanding balance owed.

7. I should not assume that if I don't contact Dr. Manzanares to schedule and keep a follow up consultation, the tests results are normal (or without abnormalities), and may not require further medical treatments or advice.

8. I understand that if I arrive late to my scheduled appointment, my session will end at the originally scheduled time if my consultation starts late, Dr. Manzanares, will make up the time at the end of the session if possible or will reduce the fee accordingly. I agree to pay the full fee for the consultation missed on my behalf that is not cancelled with a minimum 24 hours notice.

8. You will be given a copy of this acknowledgment and this will be kept on file for three years, in accordance with California state law SB 577.

Signature Date

_____ _____

Printed Name: (Patient's name if signing as a legal guardian)

_____