Ayaterra
Healing approach

Personal Health History Questionnaire

Note: Please fill out this questionnarie as accurately as possible, certain questions might seem to be irrelevant to your current condition, but each detail play an important part in diagnosis and treatment for an upcoming retreat with medicinal plants. The information provided in this questionnaire is absolutely confidential, and constitute part of your medical file.

Date:

Participant Data

Full Name : _____

Age: _____

Gender: _____

Date of Birth: _____

Nationality: _____

Email: _____

Mobile: _____

Occupation: _____

Relationship Status: _____

Emergency Contac number: _____

Cusco Hotel: _____

Type of Retreat: _____

I fully understand the value of a honest and complete health history to enable the Ayaterra center assist and provide the best care possible.

Could you please share with us what are your goals with the medecine Ayahuasca or San Pedro?

_____

_____

_____

Health History

Childhood Illness: Measles Mumps Rubella Chickenpox Rheumatic Fever

Polio None

☐ Others: _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____

☐ ☐

Vacinated against Covid-19 Yes No

Your Medical History

☐ ☐

Please indicate if you have a history of the following:

Illness:	Age at Onset:	Illness:	Age at Onset:
☐ Epilepsy		☐ Hearth Attack	
☐ Heart disease		☐ Migraines	
☐ Venereal disease		☐ Mental Illness	
☐ Bleeding disorder		☐ Autoimmune Problems	
☐ Asthma		☐ Anemia	
☐ Osteoarthrities		☐ Diabetes	
☐ Bipolar		☐ Ulcer	

☐ Cancer ☐ ☐ Seizures/Convulsions ☐

☐ Severy Allergy ☐ ☐ Bowel Disease ☐

Please kindly let us know if have undertaken a medical evaluation in the last 6 months, if so let us know the name of your liscensed physcian, and what were the results of your exam.

Have you notice if there has been any major change in your general health in the past 12 months?

Are you now under the evaluation of a Physcian's care for any particular reason?

Have you ever had any critical illnes, operations or hospitalization? If so please elaborate.

Do you have any cardiovascular disease, including heart attack?

Have you ever had high blood pressure symptoms?

Have you ever had low blood pressure symptoms?

How many cigars do you smoke per day?

How often do you drink coffe? And if so how many cups per day on regular day.

Are there any antecedents of alcohol or chemical dependency or emotional issues that may interfere with the care we provide?

Are you currently on a restricted diet? If so please let us know.

Have you ever had psychiatric or psychological diagnostic, that have entailed a treatment?

Are you currently in any sort of therapy or are you part of any group support at the moment?

Have you ever practice, yoga, meditation, reiki, or any other form self-exploration? if so explain how often.

How did you hear about our retreat center?

Current Medication:

Please list all sort of medication, supplement or vitamins, that you have been taking on a regular basis in the last month, and the date last taken.

Name	Frecuency	Date

Allergies:

Please list name of specific medication or food that have caused an adverse reaction, specify the reaction.

Medication name: _____

_____

Food: _____

Traumas or Abuse:

Have you experienced any trauma, physical or emotional abuse? If you don't feel comfortable with this method, we can also discuss about this topic privately instead.

Please elaborate: _____

_____

Family Health Background

Is there any member in your family who have had any issues related to high blood pressure or hypertension?

_____

Is there any member in your family who has been diagnosed with diabetes?

_____

Is there any member in your family who has been diagnosed with psychiatric disorders?

_____

Are your father and mother still alive? Yes ☐ No ☐

Could you please share with us how was your relationship in the past?

Could you please share with us how is your relationship now?

Do you have siblings? Yes ☐ No ☐

How many Brothers ☐ Sisters ☐

If so, could you please share with us how is your relationship with them in the past and now?

Please let us know if you have ever used any of the following substances.

			When was the last time
Cocaine	Yes ☐	No ☐	……
Mushrooms	Yes ☐	No ☐	……...
Anphetamines	Yes ☐	No ☐	……...
Marihuana	Yes ☐	No ☐	……...
Valium	Yes ☐	No ☐	……...
Heroine	Yes ☐	No ☐	……
Mezcaline	Yes ☐	No ☐	……
Crack	Yes ☐	No ☐	……
Ketamine	Yes ☐	No ☐	……
Ecstasy	Yes ☐	No ☐	……
LSD	Yes ☐	No ☐	……
Alcohol	Yes ☐	No ☐	…….
Nicotine	Yes ☐	No ☐	…….

Others: _____

_____

Only for Women:

Could you please confirm with us if is there the slighlest posibilty that you are pregnant, or if you definitely pregnant?

_____

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Participant's paspport number & Signature