Dr. Morrison's Medical Health History Questionnaire

Name: "Bear" Date: 5/21/24

Date of Birth 8/24/53 Age 70

Please list the most important reason(s) you came in today:

1. GB
2. CHF
3.
4.

What other health concerns do you have at this time?

1. lung embolism - mlb gone now
2.
3.

Please list other doctors, chiropractors, acupuncturists and physical therapists you see and for what:

1. Energy work
2. Barbara PT 2-3x week
3.

List prescription medicine you now take (include dosage, reason you take it):

Medication	Dose per Day	How long? Reason for medication
Farxiga 10mg		Eliquis
Finasteride		
Sotalol 80mg	BID	
Furosemide 20m	BID	
Interesto	26	

List over-the-counter medicines, vitamins, and food supplements you take and why?:

Supplement	Dose per Day	How long? Reason for medication
Osteonutrients	2 night	Mg Taurate 1BD
ONE Multi	1	Pure cell 2 BID
BCQ	2 BID	Lions Mane 1BID
Resevatrol	1BID	Natto kinase - yes
DHA	2 BID	Curcumin

Are there any adverse effects from any of the above? If so what is it and is it a concern?

None

Medical History (Please include dates):

Any Major illnesses that have been diagnosed or suspected:

Illness	When?	How diagnosed? (lab, imaging, symptoms)
CHF	10/23	when hospitalized w/GB
GB	11/23	- paralysis & weakness -

Red light -

Ozone

EBV Abs

received IVIG & 5 containers

next cardio 3rd June

Pure omega Ultra HP

Injury/Trauma/Accidents
What? What was injured? When?

Surgeries/Hospitalizations:
Surgery/Hospitalization When?

Anaphylactic Reactions or severe reactions (medications, food, stings) to:
~~None~~

Sensitivities (medication, supplements, foods, etc.)
cry when animals die.

What is your blood Type? A+ B+ AB+ O+ A- B- AB- O-

Recent Medical Care: Where did you last receive medical care? _____
For what reason(s)? _____

Date of last physical exam: _____ Date of last TB test: _____
Date of last lab work: _____ Date of last tetanus shot: _____

Do you visit the dentist annually or more frequently? Y N
Characterize your dental health
Poor ✓ (more than 5 fillings) ✓ more than one root canal
Good __ (3-4 fillings) ____ 1 root canal
Great __ (0-2 fillings) ____ no root canals
Gum-periodontal health ____ Mild bleeding occasionally ✓ Bleeding regularly
____ more extensive swelling/gum inflammation
Height ____ Weight 250 Max weight 300 when? fall '23 Desired weight ____

Circle if the symptom has occurred in the **last year**. Please **check mark** if the symptom occurred in **the past**, **1** for not often, **2** for occasional, **3** for often.

General last 2yrs	(Weight gain) Weight loss Weight gain (20lbs) Weight loss (20 lbs) History of dieting	Chronic fatigue Afternoon fatigue (Weakness) Excessive thirst Anemia	Spontaneous sweating Night sweats Fever/chills	Heat intolerance Cold intolerance Cold hands/feet Other:
Skin	Dry skin Itchy skin Rashes Hives Bruise easily	Acne Eczema Psoriasis Shingles Fungal Rash/ringworm	Athlete's foot Nail fungus Moles Varicose veins Bumpy skin back of arms	Any change to nails Any change to skin color Any change to moles Other:

Head	Headaches P Migraines T	Dizziness Vertigo	Trauma Hair Loss	Seizures Other:
Eyes **Last exam___**	Dry eyes Watery eyes Itchy eyes Eye pain Red eyes Eye discharge	Blurred vision Double vision Sensitive to light Poor night vision	Styes Cataracts Vision loss Other:	Vision correction: Nearsighted Farsighted Contacts Glasses Laser
Ears	Ear pain Itchy ears Waxy ears	Discharge from ears Ringing in ears Hearing loss	Ear infections Ear infections as child	Hearing Aids Other
Nose & Sinuses	Itchy nose Discharge from nose Phlegm	Hay-fever/Allergies Post nasal drip Nosebleeds Loss of smell	Breathes thru mouth Snores	CPAP use Other:
Mouth & Throat Last dental exam WK	Dry mouth Itchy mouth/lips Sores on mouth/lips Bad breath	Sore throat Difficulty swallowing Loss of taste Hoarseness	Dentures Inflamed/bleeding gums Teeth sensitivity Braces	Jaw clicking TMJ
Neck	Neck pain	Swollen glands	Trauma	Other:
Respiratory CAF	Shortness of breath Wheezing Pain with breath Coughing up blood	Asthma Bronchitis/Pneumonia Persistent cough	Exposure to: Chemicals Solvents Particulates	Tuberculosis Other:
Cardiovascular Last EKG ___	High blood pressure Low blood Pressure High Cholesterol Chest pain Heaviness in legs Bleeding issues	Heart races Palpitations Chest tightness Difficulty breathing at night Swelling in ankles Stroke	Cold hands/feet Purple fingers/lips Heart murmur Dizzy on standing Exhaustion with mild exertion	Clots Varicose veins Spider veins Calf pain-night Calf pain-walking Other:
Gastrointestinal (upper) Last endoscopy ------	Poor appetite Excessive appetite/thirst Changes in appetite Trouble swallowing Stomach pain	Nausea Vomiting Burping Belching Heartburn H. pylori Ulcers	Intolerance to foods: (list food &rxn))	Fatigue after eating Anal itching Liver disease Gall bladder disease Treated for parasites
Gastrointestinal (lower) Last colonoscopy ___ Last rectal exam ____	Abdominal pain Abdominal bloating Gas/flatulence History of abdominal/pelvic surgery	Constipation <1 stool a day Painful Stool Hemorrhoids Blood in stools Blood on stools D/T stuck in bed	Stool hard to pass Foul smelling stool Loose stools Frequent stools >3 day Undigested food in stools	Stool shape: -one piece -little pellets -breaks up -other: Color: -yellow -green -brown -black

Kidney/Urinary	Frequent urination Urinate <3x day Can't hold urine Urination with cough or sneeze Now uncatheterized.	Kidney infections Bladder infections Urination at night Pain/burning with urination	Dripping after urination Bed-Wetting Other:	Color: Light yellow Dark yellow Red urine Cloudy Strong smelling
Musculoskeletal L side paralysis + pain	Pain in- Arms Shoulders Neck Hands Upper back Lower back Hips Legs Knees Feet	Painful bones Tight Shoulders Pain Muscles Swollen knees/elbows Burning Spasms/cramps Morning stiffness	Chronic pain Loss of height Osteoporosis Unable to sit straight Activities Limited due to pain	Herniated/bulging disc Arthritis Rheumatoid arthritis Tendonitis # Broken bones ___ DEXA Y N When____Normal?
Neurological	Fainting Dizziness/vertigo Numbness/tingling Where?_____ Trembling hands	Poor Concentration Memory loss -long-term -short term Lack of alertness	Loss of grip Loss of muscle tone Muscle weakness Head heavy Heavy extremities	Head trauma Other:
Endocrine	Hypothyroid -surgical -Hashimoto's -unknown cause Hyperthyroid Cold hands/feet Cold intolerance	Hypoglycemia Hyperglycemia -DM1 -DM2 -Medications Y N Excessive thirst	Fatigue Poor appetite Excessive Hunger	Unexplained weight gain / loss Other:
Immune GB	Slow wound healing Reactions to Vaccines Cancer Mononucleosis	Chronic fatigue syndrome Auto immune disorder GB	Chronically swollen glands Chronic Infections Chicken pox Shingles	Frequent colds/flus Herpes Warts Other:
Women only	Menses: Age of first: _____ Days bleed:_____ Length of cycle:_____ Date of last menses: Heaviest flow day:___ Heavy days #pads/tampons:_____ Clots? Cramps 1 2 3 4 5 Medication Y N Occ Hysterectomy_____ Fibroids Cystic Pain	Sexually active Y N # Pregnancies ____ # Live births ____ Gender you are sexually active with? Men Women Both Type of birth control? -Birth control pills -IUD Cu+ / Hormone -Condoms -Implant -Depo shot - Vasectomy -Other	Spotting between menses PMS -irritability -moodiness -crave sweet -crave salt -bloating -breast tenderness -crave salt Fatigue with menses Miss menses Irregular menses	Vaginal -itching -discharge -odor -dryness Infections -yeast -bacterial -viral History of STI Y N _____ Difficulty conceiving Libido 1-5 _____
Women only	Breast Monthly self exam Y N Fibrous breast Breast fed a child Implants Reduction Nipple discharge	History of mammogram Abnormal mammogram + PAP history -Cryo -LEEP	Menopause Age __Yrs ago___ Hot flashes Night sweats Moodiness Brain fog Vaginal dryness	Hormone replacement -standard -natural -herbal Other:

Men only PSA test ____ Prostate exam _____	Sense of full bladder Difficulty urinating Pain with urination Wake >1x to urinate Dripping after urination Strain with urination Discharge from penis Sore on penis	Discharge from penis Sore on penis History of STI Y N Premature ejaculation Erectile dysfunction Sexual difficulties Libido 1-5 ___	Testicular pain Testicular lump Testicular monthly exam Y N History of prostatitis Pain in genitals Hernia	Sexually active Y N Gender you are sexually active with? Men Women Both Type of birth / STI control? Vasectomy_____ Condoms _____
Emotional & Mental	Unexplained crying Loss of interest • Boredom Restless Panic attacks Aggression	Self-blame Excessive guilt Socially withdrawn Irritability • Worry Loss of confidence / self-esteem loss hope oc	Indecisiveness Inability to concentrate Anxiety Overly concerned with social encounters Thought of suicide	Memory impaired • -recall words -learn new tasks Unable to recognize or identify objects Disturbance in planning or execution of plan
Sleep	Difficulty falling Difficulty staying Wake refreshed	Wake catching breath Snore Wake tired	Hours sleep ____ Hours Sleep needed ___ 6 hrs 1-2 nap	Apnea Treatment Y N
Exercise	Never 0-2 x week 2-5 x week 5 + x week	Intense Moderate Easy going	Bike Swim Hike Weights Run Gym	Other:
Lifestyle meditation -	Spiritual participation Yoga - yes past Tai chi Chi kung Meditation yes Other:	Art ✓ Knitting Quilting Drawing Photography Other _____	Married Y # Children 1 # Children living with you ___ 1 child .17	Use of Daily/Weekly/Monthly Alcohol 0-rare Marijuana not much - Tobacco none Other ___
Average Diet (what you eat) **Quantity ?** **Water** tea herb **Coffee** 1 cup am **Tea** herbal **Wine** rare **Beer** rare **Cocktail** **Other:** 1° healthy SAD diet is berry fed by whoever cooks - mostly healthy	Breakfast When What: Beverages	Lunch When What: Beverages	Dinner When What: Beverages	Snacks When What: Other Beverages

Has anyone in your family had and who?

Alcoholism	Arthritis	Asthma	Cancer: type _____
_____	_____	_____	_____
_____	_____	_____	_____

Glaucoma	Diabetes	Heart disease	Genetic disorder
_____	_____	_____	_____
_____	_____	_____	_____

Mental illness	Gastrointestinal	Thyroid disease	Auto-immune
_____	_____	_____	_____
_____	_____	_____	_____

Other_____

Rate your stress level (1=low 10=very high) 1 2 3 4 5 6 7 (8) 9 10

Circle and rate the contributors

Health ~~///~~ Work ___ Money ___ Kids ____ Marriage____Parents ___ Home ___

Other _____

In your everyday life, your present faith/spiritual practices are (1= Important, 10= very important)

1 2 3 4 5 (6) 7 8 9 10

Please rate your motivation to affect change in your health (1= unmotivated, 10= highly motivated)

1 2 3 4 5 6 7 (8) 9 10

Hobbies:

_____

What do you do that brings you joy? Nature

_____

Anything Else? _____

_____

Patient signature_____Date _____

Thank you for taking the time to provide this information so that we may provide you with more effective care.

Element – Fire Metal Water Air Earth – Pictures Sage/shell

Addendum For Yoga Therapy

Prioritizing your physical body (skeletal, muscles, pain) name the most limiting to your life to the least limiting.

1. L arm Leg improving – pain but can. –
2. L knee IP band.
3. other shoulder Right –
4. numbness around pelvis +

Do you have mobility restrictions? What are they? – L side

How would you describe your breathing? inadequate –

When is your energy best and worst?

Season? Best Summer Worst Winter lack light –

Time of day? Best am Worst

What would you change about your sleep? Δ position side sleeper.

Overall How is your digestion 1 poor - 10 great 8

Food preferences (circle all apply) salty sour sweet pungent spicy bitter

Diet is (Approx) % (week) 25 meat 5% fish 10 veg (raw) 20 veg (cooked)
15 grain 15 potatoes 10% fruit
20 @ processed 65 homemade 0 fast food 15 good restaurant

Meals per Day 2-3 meals a day When

What interests do you have? music walk/hike. bike

Do you actively engage in interests? music – reading –

Do you require motivation? yes too much weed.

3 Words that describe your personality 1 Sincere
2. Loving 3. Eager to learn - Curious

What is deeply meaningful to you? Nature

How much do you devote to this? not now – need energetics.

How do you Cope with stress or difficult issues? – self mod thoughts

Circle those above you consider positive

What would you like to learn or teach others?
to paint. –

INTEGRAL YOGA
Client Release and Waiver of Liability Agreement

I, Terry Robinson (Client), as a client of Madeleine Morrison ND (Intern), hereby agree to the following:

RELEASE AND WAIVER OF LIABILITY

1. I am voluntarily participating in the Integral Yoga Therapy Practicum ("Practicum") which may involve physical, mental, emotional and spiritual wellness and Yoga practices offered by Madeleine Morrison (Intern). I am fully aware that the Intern is in training in the Integral Yoga Therapy Certification program, and at this time is not a Certified Yoga Therapist. I further understand that the Intern will be mentored by a Certified Yoga Therapist during the time completing the Practicum.

2. I recognize that I am choosing to participate in the Practicum in my current state of physical, mental, and emotional health. I understand that the Practicum may require physical exertion, and I represent and warrant that I am able to clearly communicate my physical capabilities and limitations, and I have no reason which would prevent my full participation in the Practicum. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the Practicum. If I have consulted a physician, I have taken and will continue to take the physician's advice. I understand that the Intern reserves the right, at their complete discretion, to refuse my participation in the Practicum. I understand that I have the right and duty to refuse any activity that may be perceived as counter to my physician's advice, or which feels painful or unsafe.

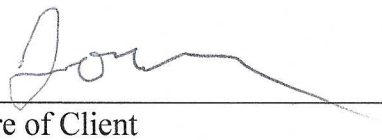
3. I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of participating in the Practicum.

4. In further consideration of being permitted to participate in the Practicum, I knowingly, voluntarily and expressly waive any "Claim" (as defined below) I may have against the Intern, Integral Yoga owners, members, employees, and/or its instructors, teachers, volunteer staff, workshop presenters, independent contractors and the landlord of the Intern (each, a "Released Party") for any Claim that I may sustain as a result of participating in the Practicum even if the Claim arises from the negligence of any Released Party or anyone else. I agree to indemnify and hold harmless each Released Party from any loss or liability incurred in defending any Claim made by me or any third party (including the employees and agents of the Intern and its contractors) even if the Claim is alleged to or did result from the negligence of any Released Party. "Claim" includes but is not limited to any and all liabilities, claims, demands, expenses, fees (including attorneys' fees), legal actions, rights of actions for damages, personal injury, property damage, mental suffering and distress or death that I may suffer, my children or unborn child may suffer (including any legal fees or expenses) in connection with participation in any Practicum.

5. I, my heirs or legal representatives forever release, waive, discharge and covenant not to sue any Released Party for any Claim caused by any negligence or other acts of a Released Party.

6. This agreement shall be construed in accordance with, and governed by, the laws specific to the State I am receiving my training. I have carefully read this release and waiver of liability and fully understand its contents. I voluntarily and knowingly agree to the terms and conditions stated herein. I

am aware that by signing this release and waiver of liability, I am giving up substantial rights that I or my heirs and assigns may have against any Released Party.



Signature of Client

Jerry Robinson

Printed Name of Client

Date