HEALTH FORM

takiwasi

PERSONAL INFORMATION

Name | Last Name

Date of Birth | Age | Sex ☐ Male ☐ Female | Religion

Civil Status ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Cohabitation ☐ Other | No. of Children

Level of Education | Profession/Occupation

Document (ID) Choose Type | Language | Do you speak Spanish? Choose Level

Place of Birth (City) | Nationality

Country of residence | City of residence

Current address

Telephone (landline) | Mobile Phone

Email

Contact person in case of emergency

Name | Last Name

Relationship | Country of residence

City | Email

Telephone (landline) | Mobile Phone

Current address

Please answer the following questions with complete honesty. TAKIWASI CENTER will not be held responsible for any problem arising due to omissions or lack of honesty in answering the following questions.
Answer all the questions by marking either YES or NO. If you answer YES, please detail your answer on the space provided or if necessary on an extra sheet.
Please notify us if you have any illness, pathological or functional problem (physical or mental) not mentioned here.

I. CURRENT MEDICAL STATE

1. Are you currently suffering from any illness? ☐ NO ☐ YES
   Which one/s? Time frame of illness?
2. Do you currently have complaints or symptoms? ☐ NO ☐ YES
   Which one/s?
3. Are you currently taking any medication? ☐ NO ☐ YES
   Which one/s? (specify dose)
   Since when?
   Has/have the medication/s been prescribed to you? ☐ NO ☐ YES
4. Did you recently (within the past 6 months) receive any vaccinations? ☐ NO ☐ YES
   Which one/s?
5. Have you received a vaccine against COVID Sars-Cov-2? ☐ ☐
   How many doses did you receive? | Brand
6. Height ____ m. | Weight ____ kg.

II. HABITS

Appetite ☐ Normal ☐ Increased ☐ Diminished
Sleep ☐ Normal ☐ Increased ☐ Diminished
Stools ☐ Normal ☐ Diarrhea ☐ Constipation
Urine ☐ Normal ☐ Abnormal

Do you follow a specific type of dietary regimen? ☐ NO ☐ YES
Please describe your diet

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III. PERSONAL PATHOLOGICAL ANTECEDENTS

Have you suffered from any of the following ilnesses, signs, or symptoms?
If you answer is affirmative, please indicate approximately in which year that was or when it had started. If necessary, specify the relevant details on a separate sheet.

1. Infectious Diseases

Hepatitis ☐ NO ☐ YES Type A ☐ B ☐ C ☐ Year ☐
Typhoid ☐ NO ☐ YES Year ☐
Malaria ☐ NO ☐ YES Year ☐
Sexually Trasmitted Diseases ☐ NO ☐ YES Year ☐
Diagnosis ☐ Treatment ☐ NO ☐ YES
HIV (+) ☐ NO ☐ YES Year ☐
AIDS ☐ NO ☐ YES Year ☐
Others ☐ Year ☐

2. Digestive Diseases

Gastro duodenal ulcer or gastritis ☐ NO ☐ YES Year ☐
Are you receiving treatment? ☐ NO ☐ YES Which type/s? ☐
Are you still having symptoms? ☐ NO ☐ YES Which type/s? ☐
Hemorrhage of the digestive system ☐ NO ☐ YES Year ☐
Hepatic-billiard dysfunctions (liver or gall bladder) ☐ NO ☐ YES Year ☐
Specify which ☐
Jaundice ☐ NO ☐ YES Year ☐
Hiatal hernia ☐ NO ☐ YES Year ☐
Surgeries on the digestive system ☐ NO ☐ YES Year ☐
Specify which ☐
Do you have a problem with vomiting? ☐ NO ☐ YES Year ☐
Specify which ☐
Others ☐ Year ☐

3. Chronic Respiratory Diseases

Asthma ☐ NO ☐ YES Year ☐
Tuberculosis ☐ NO ☐ YES Year ☐
Others ☐ Year ☐

4. Cardiovascular Diseases

Congenital alteration ☐ NO ☐ YES
Precise diagnosis ☐
Infarct ☐ NO ☐ YES Year ☐
Angina Pectoris / pre-infarct ☐ NO ☐ YES Year ☐
Cerebro-vascular accident ☐ NO ☐ YES Year ☐
Cardiac Insufficiency ☐ NO ☐ YES Year ☐
Arterial hypertension or hypotension ☐ NO ☐ YES Year ☐
Are you receiving any treatment? ☐ NO ☐ YES Year ☐
Specify treatment and duration ☐
Indicate **values without treatment** Systolic pressure (high) ☐ Diastolic pressure (low) ☐
Indicate **current values** Systolic pressure (high) ☐ Diastolic pressure (low) ☐
Cardiac rhythm disorders ☐ NO ☐ YES Year ☐
Specify which type ☐
Heartvalve disease ☐ NO ☐ YES Year ☐
Others ☐ Year ☐

5. Diseases of the nervous system

Headache, migraine ☐ NO ☐ YES Year
Convulsions ☐ NO ☐ YES Year
Specify
Epilepsy ☐ NO ☐ YES Year
Vertigos ☐ NO ☐ YES Year
Sciatica ☐ NO ☐ YES Year
Others Year

6. Psychiatric illnesses

Have you ever been diagnosed with a psychiatric or psychological condition? ☐ NO ☐ YES Year
Specify which one
Have you ever been hospitalized in conjunction with this psychiatric condition? ☐ NO ☐ YES Year
Duration, frequency, context, type of medication
Psychoterapeutic attendance ☐ NO ☐ YES Year
Suicide intents ☐ NO ☐ YES Year
Personality disorders ☐ NO ☐ YES Year
Specify
Have you had episodes of anorexia/bulimia? ☐ NO ☐ YES Year
Specify
Others Year

7. Autoimmune diseases ☐ NO ☐ YES

Which one/s? Year

8. Metabolic diseases

Diabetes ☐ NO ☐ YES Year
Specify type, medication, compensated or not, complications
Excess of cholesterol/triglycerides ☐ NO ☐ YES Year
Others Year

9. Diseases of the genitourinary system

Acute ☐ NO ☐ YES Year
Chronic ☐ NO ☐ YES Year
Diagnosis and medication

10. Sexual problems or dysfunction ☐ NO ☐ YES

Which type/s? Year
Have you ever experienced any illness or had operations of the sexual organs? ☐ NO ☐ YES
Which? Year

11. Diseases of the skin (including nails, hair) ☐ NO ☐ YES

Which type/s? Year

12. Tumors

Benign ☐ NO ☐ YES Year
Malignant ☐ NO ☐ YES
Which type/s? Year

13. Diseases of the blood ☐ NO ☐ YES

Which type/s? Year

14. Allergies ☐ NO ☐ YES

Specify Year

15. Diseases of the endocrine system (thyroids, ovaries) ☐ NO ☐ YES

Which type/s? _____ Year _____

16. Accidents/Injuries ☐ NO ☐ YES

Specify _____ Year _____

17. Hospitalizations ☐ NO ☐ YES

Reason _____ Year _____

Specify _____

18. Operations ☐ NO ☐ YES

Specify _____ Year _____

19. Disability ☐ NO ☐ YES

Level _____ Year _____

20. Gynecological/obstetric antecedents (women only)

Contraceptive pills or injections ☐ NO ☐ YES

No. of pregnancies _____ No. of children _____ Alive _____ Deceased _____

Problems during pregnancies and childbirth? _____

Abortions ☐ NO ☐ YES How many? _____

Spontaneous (How many?) _____ Year _____

Induced (How many?) _____ Year _____

Fertility treatments? _____

Problems with menstrual cycle? ☐ NO ☐ YES

Specify _____

21. Reproductive antecedents (men only)

Which type of contraceptive method do you use? _____

No. of pregnancies _____ No. of children _____ Alive _____ Deceased _____

Abortions ☐ NO ☐ YES How many? _____

Spontaneous (How many?) _____ Year _____

Induced (How many?) _____ Year _____

Fertility treatments? _____

22. Sexuality

Defined sexual identity ☐ NO ☐ YES Sexual orientation _____

Disorder of sexuality? _____

IV. FAMILIAL PATHOLOGICAL ANTECEDENTS

1. Are there antecedents of any type of illness in your family? ☐ NO ☐ YES
(especially diabetes, epilepsy, hypertension, heart problems, psychiatric disorders)

Which type/s? _____

2. Is there any hereditary disease in your family? ☐ NO ☐ YES

Which type/s? _____

V. OTHER ANTECEDENTS

1. Do you have any type of problem that has not been previously mentioned? ☐ NO ☐ YES

VI. CONSUMPTION OF PSYCHOACTIVE SUBSTANCES

WITHOUT RITUAL CONTEXT

SUBSTANCE	NO	YES	¿DURING WHAT TIMEFRAME HAVE YOU BEEN USING? Indicate number of months or years and the date of last use	FREQUENCY OF CONSUMPTION Indicate how many times and for how long	APPROXIMATE DATE OF LAST CONSUMPTION
Cocaine	☐	☐			
Cocaine base paste	☐	☐			
Crack	☐	☐			
Morphine	☐	☐			
Heroine	☐	☐			
Codeine	☐	☐			
Marihuana	☐	☐			
Hashish	☐	☐			
Alcohol	☐	☐			
Tobacco	☐	☐			
Amphetamines	☐	☐			
LSD	☐	☐			
Ecstasy	☐	☐			
Synthetic drugs	☐	☐			
Specify					
Pharmaceuticals	☐	☐			
Specify					
Others	☐	☐			

Do you consider yourself dependent on or addicted to one or more of the above substances? ☐ NO ☐ YES

Which one/s?

WITH RITUAL CONTEXT

SUBSTANCE	NO	YES	IN WHICH CIRCUMSTANCES? Ritual guided by a maestro, alone or recreational	FREQUENCY OF CONSUMPTION Indicate how many times and for how long	APPROXIMATE DATE OF LAST CONSUMPTION
San Pedro Wuachuma	☐	☐			
Mushrooms	☐	☐			
Peyote	☐	☐			
Ayahuasca	☐	☐			
Iboga	☐	☐			
Kava-kava	☐	☐			
Salvia divinorum	☐	☐			
Others	☐	☐			
Indicate which one/s					

VII. EXPERIENCES WITH MODIFIED STATES OF CONSCIOUSNESS (MSC)

1. Have you ever experienced a MSC **without the consumption of psychoactive substances**? ☐ NO ☐ YES

Spontaneous ☐ NO ☐ YES

In which circumstances?

When did the last episode occur?

With what frequency have you experienced this?

Induced ☐ NO ☐ YES

In which circumstances?

When did the last episode occur?

With what frequency have you experienced this?

Near-death experiences ☐ NO ☐ YES

In which circumstances?

When did the last episode occur?

With what frequency have you experienced this?

Mediumistic or paranormal phenomena ☐ NO ☐

In which circumstances?

When did the last episode occur?

With what frequency have you experienced this?

VIII. PRACTICE OR USE OF ALTERNATIVE MEDICINE

Please indicate if you are a user or a practitioner of any of the following treatment practices and specify its respective name:

	NO	YES	Indicate name of practice	Indicate whether you are a user or a facilitator/guide/instructor of other persons
Alternative medicine: Ayurveda, Chinese, Homeopathic, Anthroposophic, etc.	☐	☐		
Techniques for self-exploration: Meditation, Yoga, etc.	☐	☐		
Reiki	☐	☐		
Use of medicinal plants	☐	☐		
Use of psychoactive plants	☐	☐		
Other practices	☐	☐		

Please indicate if you have practiced or experienced periods of retreats, diets, seclusion, etc. with the aim of self-exploration, learning, healing or spiritual seeking

NAME OF THE PRACTICE OR EXPERIENCE	GOAL	DURATION OF THE EXPERIENCE Indicate days, weeks, months	FREQUENCY Indicate weekly, monthly, annually

Would you like to add anything (comment, precision, additional information)?

Me, _____ ,

I guarantee that the above information has been given truthfully. I exonerate Takiwasi Center and take full responsability for the consequences of any omission or lack of truthfulness. I hereby make known that i am participating voluntarily in the therapeutic activities conducted by Takiwasi.

Place _____ Date _____

Signature _____