Bwiti
Where Healing Begins

DATE:_____

MEDICAL QUESTIONNAIRE

NAME: **GENDER:** ■ MALE ☐ FEMALE

First, Middle, Last

ADDRESS:

Street Name Apartment # Postal/Zip code

City Province/State Country

PHONE #:

Home: Work: Cell:

EMAIL: **OHIP/INSURANCE #:**

DOB: / / **AGE:** **HEIGHT:** **WEIGHT:**

Day / Month / Year

If under 18, must provide parental consent. Both parents signatures if available.

EMERGENCY CONTACT INFO:

Name: First, Middle, Last Relationship To Client

ADDRESS:

Street Name Apartment # Postal/Zip code

City Province/State Country

PHONE #:

Home: Work: Cell:

NOTES (For Bwiti Staff):

MEDICAL REQUIREMENTS: (Check all that apply)

☐ SLEEP APNEA ☐ LIVER CONDITION ☐ HIGH BLOOD PRESSURE ☐ SEIZURE DISTORTER

☐ ASTHMA ☐ KIDNEY CONDITION ☐ HEART CONDITIONS

PHYSICAL MEDICAL HISTORY: (Check all that apply)

- ☐ LIVERY PROBLEMS
- ☐ KIDNEY PROBLEMS
- ☐ THYROID CONDITION
- ☐ RESPIRATORY ISSUES
- ☐ CHRONIC INFECTION
- ☐ DIGESTIVE ISSUES
- ☐ STD
- ☐ HIV/AIDS
- ☐ CANCER
- ☐ DIABETES
- ☐ STROKE
- ☐ BRAIN INJURY

TELL US ABOUT THE CONDITION:

I HAVE TAKEN OR AM TAKING: (Check all that apply)

- ☐ OPIATES (OXYCONTIN, FENTANYL, HYDROCODONE)
- ☐ METHADONE/ SUBONXONE
- ☐ BENZODIAZEPINES (XANAX, KLONOPIN (CLONAZEPAM), VALIUM, ATIVAN (LORAZEPAM)
- ☐ SSRIS

LIST OF MEDICATIONS: Make sure to include: Present and past, name and quantity and length of time

REASONS FOR MEDICATIONS:

I CONSENT TO A URINE DRUG TEST ■ YES ☐ NO

NOTES (For Bwiti Staff):

MENTAL MEDICAL HISTORY: (Check all that apply)

- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ PANIC ATTACKS
- ☐ PTSD
- ☐ BIPOLAR
- ☐ ADD/ADHD
- ☐ SCHIZOPHRENIA
- ☐ EATING DISORDERS
- ☐ SEXUAL DISORDER
- ☐ SUICIDAL THOUGHTS OR TENDENCIES

TELL US ABOUT THE CONDITION:

HAVE YOU BEEN HOSPITALIZED FOR MENTAL HEALTH ISSUES ■ YES ■ NO

ARE YOU CURRENTLY OR HAVE BEEN UNDER THE CARE OF A MENTAL HEALTH PROFESSIONAL ☐ YES ■ NO

NOTES (For Bwiti Staff):

I HAVE USED OR AM USING: (Check all that apply)

- ☐ ALCOHOL
- ☐ CANNABIS
- ☐ CAFFEINE
- ☐ COCAINE
- ☐ HEROIN
- ☐ TOBACCO
- ☐ CRACK
- ☐ METH
- ☐ OPIATES/PAIN MEDICATIONS (MORPHINE, OXYS, FENTANYL, ETC)
- ☐ OTHER _____

LIST OF STREET DRUG HISTORY: Make sure to include: Present and past, name and quantity and length of time

HAVE YOU SOUGHT OUT TREATMENT: (For addiction or dependency Where? When? Why?)

LIST ALLERGIES:

OTHER:

NOTES (For Bwiti Staff):

DISCLAIMER:

I hereby certify that all statements and answers provided in this questionnaire are true to the best of my knowledge.
Due to the sensitivity of Iboga and the Bwiti healing process, it is imperative that all information be provided be true and current.

I, _____ am fully aware of the sensitivity of Iboga and the Bwiti healing process. _____

I, _____ Insure that all information provided is true and current. _____

I, _____ understand that any information withheld is at my own risk. _____

Client Name: _____ **Witness Name:** _____

Client Signature: _____ **Witness Signature:** _____

Date: _____ **Date:** _____

info@bwiti.ca