P: 419-878-8312 F: 419-878-8844 751 Michigan Avenue, Waterville, Ohio 43566

Heart Sound Recorder / Coaching Client Intake Form

Name: ______________________________ DOB: __________

Address: ______________________________ Phone #: ____________

Email: ______________________________

Occupation: ______________________________

Marital Status (circle): Single Married Partnered Separated Divorced Widowed

Children (circle): Yes No Number of Children: _____ Age(s): ____________

Emergency Contact: ______________________ Relationship: ______________

Emergency Contact Phone: ______________________

How did you hear about us? ______________________________*

*May we thank the person who referred you and mention your name: Yes No

Family Health History: Do any primary family members (i.e. parents, siblings) have any of the following:

□ Heart Disease □ Diabetes □ High Blood Pressure □ High Cholesterol

Personal Health History: Have you been diagnosed with any of the following:

□ Heart Disease □ Diabetes □ High Blood Pressure □ High Cholesterol

List all surgeries, hospitalizations or major accidents including date occurred:

1.) ______________________________________

2.) ______________________________________

3.) ______________________________________

Prescription Medications	Dose	Reason for Taking	Taking Since
____________________	__________	______________	______________
____________________	__________	______________	______________
____________________	__________	______________	______________
____________________	__________	______________	______________

Supplements or OTC Medications	Brand	Dose / Frequency
____________________	______________	______________
____________________	______________	______________
____________________	______________	______________
____________________	______________	______________
____________________	______________	______________

Social History:

Do you smoke? Yes No For how long? __________ Packs per day: ____________

Do you drink alcohol? Yes No Number of drinks per week: ____________________

History of recreational drug use? Yes No

Do you drink caffeine? Yes No In what form? ____________________

How much caffeine per day? ____________________

Stress Level (circle): High Medium Low Primary Stressor: ____________________

Do you exercise? Yes No Frequency (days / week): __________

What type of exercise? ____________________

How many hours do you sleep per night? ____________

What is the quality of your sleep? (0=worst, 10=best) ______________

What do you eat in a typical day (including what time):

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

Beverages: ____________________

Do you have any specific concerns about your heart? ________________________________

____

____

Are you currently seeing other health care professionals?

Primary Care Physician: ____

Specialist Physician: ____

Naturopathic Doctor: ____

Chiropractor: ____

Other: ____

How committed are you towards making changes in your health?

Slightly Moderately Very

0 1 2 3 4 5 6 7 8 9 10

What is your main reason for wanting to improve your heart health right now: ____________

____

____

____

____

Is there anything else you would like to share that has not been covered on this intake form or on the Cardiovascular Systems Survey?____

____

____

____

Heart Sound Recorder Patient Consent Form

I give ____________________ permission to record the sound of my heart and to create a graph of that sound on the Heart Sound Recorder (a general wellness cardiac stress monitor). I have been informed and understand that the Heart Sound Recorder is not an electrocardiograph like those in hospitals or physicians and that it is not capable of diagnosing heart conditions and is not in any way a substitute for such a device. I further understand that the Heart Sound Recorder has not been reviewed or cleared by the US Food and Drug Administration. I understand that if I have or believe I have a heart condition, that I should see a physician qualified to evaluate and treat that condition.

Any suggested nutritional or dietary advice is not intended as treatment or therapy for any disease or symptom of disease. Nutritional counseling, supplement recommendations, and exercise considerations provided to me are to support the normal physiological processes of the body.

I understand that any techniques, treatments, or lifestyle changes suggested after the use of this device should be undertaken only with the guidance of a licensed physician, therapist, or healthcare practitioner.

The findings from this device can be used to support, but should not be used in place of sound medical therapies and recommendations.

I am giving permission to ________________________ to share my graph with other practitioners for educational purposes only so long as my name and other personal information are removed.

By signing below, I agree to the above.

Print Name: ______________________________________

Signature :___________________________________

Date:__________

HEART SOUND RECORDER SURVEY FORM

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

If a symptom does not apply, do not circle anything for that symptom.

Name:______________________

Date:______________________

Age: ________ DOB: ________ M / F

Height________ Weight: ______

1. 1 2 3 Ringing in ears
2. 1 2 3 Dizziness
3. 1 2 3 Tired throughout day
4. 1 2 3 Swollen ankles
5. 1 2 3 Poor circulation
6. 1 2 3 Breathing challenges

7. 1 2 3 Afternoon "yawner"
8. 1 2 3 Difficulty catching breath, especially during exercise
9. 1 2 3 Aware of "breathing heavily"
10. 1 2 3 Tightness or pressure in chest, worse on exertion
11. 1 2 3 Fatigue upon exertion
12. 1 2 3 Hands and feet go to sleep easily, numbness
13. 1 2 3 Muscle weakness
14. 1 2 3 Muscle cramps, worse during exercise, get "charley horse"
15. 1 2 3 Muscle spasms

16. 1 2 3 Heart pounds at night
17. 1 2 3 Heart races after alcohol consumption
18. 1 2 3 Heart races

19. 1 2 3 Heart flutters
20. 1 2 3 Sensitive to cold

Yes No Daily bowel movement

Are you taking any of the following medications?

Yes No Cholesterol If yes, name of medication:______________________

Yes No Blood pressure If yes, name of medication:______________________

Yes No Blood sugar If yes, name of medication:______________________

Yes No Other If yes, name of medication:______________________

____

Yes No **Are you taking any additional supplements?** If yes, names of supplements:______________________

____

____

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

___/___ Blood Pressure

_____ Enzyme Point

_____ Heart Rate

_____ Holding Breath Test (20 sec minimum)

_____ Hydrochloric Acid Point

_____ Murphy's Sign (Gallbladder)

_____ pH of Saliva

_____ SpO_2%

Cuff Test: Pass / Fail Cuff Pressure: ________

Pupil Dilation Exam: Pass / Fail

RESTRICTIONS ON USE The Heart Sound Recorder Survey is to be used only by trained health care professionals. If you are a patient, you should not use the Heart Sound Recorder Survey. If you are not a trained health care practitioner, you should not use the Heart Sound Recorder Survey. Health care practitioners should only use the Heart Sound Recorder Survey to provide services that are within the scope of their license or professional training. The Heart Sound Recorder Survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.

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