



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)							Language
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			



III. PERSONAL PATHOLOGICAL ANTECEDENTS

Have you suffered from any of the following illnesses, 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			
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

Which one/s?	NO	YES	Year
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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

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

11. Diseases of the skin (including nails, hair)

Which type/s?	NO	YES	Year
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12. Tumors

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

13. Diseases of the blood

Which type/s?	NO	YES	Year
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14. Allergies

Specify	NO	YES	Year
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HEALTH FORM

Takiwasi

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? (especially diabetes, epilepsy, hypertension, heart problems, psychiatric disorders)	NO	YES
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
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VI. CONSUMPTION OF PSYCHOACTIVE SUBSTANCES

WITHOUT RITUAL CONTEXT

SUBSTANCE	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
	NO	YES		
Cocaine				
Cocaine base paste				
Crack				
Morphine				
Heroin				
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	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
	NO	YES		
San Pedro Wuachuma				
Mushrooms				
Peyote				
Ayahwasca				
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?



HEALTH FORM

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



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Me,

I guarantee that the above information has been given truthfully. I exonerate Takiwasi Center and take full responsibility 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