Instructions

We invite you to fill out the qualifying intake, as there are some contraindications with IBOGA and some may need extra steps before attending a retreat.

Please note: all fields are required if you do not have an answer, please type N/A thank you.

Personal Information

First Name		Last Name	
Email		Phone	
Address			
State		City	Zip

DOB			☐ Female ☐ Male
Height	Cm	Weight	Kg

How did you hear about us? ☐ Word of Mouth ☐ Event ☐ Facebook ☐ Instagram

Please list name if referred

Why are you seeking an Iboga retreat at this time?

Habits

a) **Do you drink alcohol?** ☐ **NO** ☐ **YES** Qty per week _____

b) **Do you smoke tobacco, e-cigarettes?** ☐ **NO** ☐ **YES** Qty per week _____

c) **Do you take recreational drugs?** ☐ **NO** ☐ **YES** Qty per week _____

d) Any prescribed and non-prescribed ☐ **NO** ☐ **YES** Qty per week _____

If yes please detail below

Question # Medication is linked to	Medication	Amount of Dosage (mg)	Date Started	Date Ended	Comments

Medical History

Are you seeking to resolve any of the following?

- ☐ Anxiety
- ☐ Depression
- ☐ PTSD
- ☐ Grief
- ☐ Self-esteem issues
- ☐ Abandonment issues
- ☐ All Abuse (physical, sexual, emotional or mental)
- ☐ Guilt
- ☐ Shame
- ☐ Anger
- ☐ Fear
- ☐ Negative thinking patterns
- ☐ Physical healing
- ☐ Generational clearing - family of origin issues
- ☐ Guidance for major life shifts
- ☐ Feeling stuck
- ☐ OCD
- ☐ Eating disorders (anorexia, bulimia, binging, laxatives, pica, restrictive food intake)
- ☐ ADHD
- ☐ Addictions (alcohol, sex, drugs-prescription or recreational, gambling, porn, TV, internet, shopping, smoking, food, exercise, relationships/love, cosmetic surgeries)
- ☐ Trauma (all types and combat, terrorism, held hostage or imprisoned, natural or man-made disasters, diagnoses for life threatening illness, torture)
- ☐ Suicidal or are having thoughts
- ☐ Self-harm (any type - cutting, picking, scratching, pulling out hair, biting incl nails)
- ☐ Major Accidents
- ☐ None of the above apply to me.
- ☐ Other:

Please explain the above checked box in terms of length of time and how it impacts your life.

1. **Have you or do you have planed any surgeries and any use of anesthesia in the last month?** (such as severe asthma, sleep apnea, chronic bronchitis, emphysema, cystic fibrosis or any other) **Please *give details*** ☐ **NO** ☐ **YES**

2. **Have you or are you currently using Opioids?** ☐ **NO** ☐ **YES**
(codeine, Hydrocodone (Vicodin, Hycodan) Morphine (MS Contin, Kadian) Oxycodone (oxycotin, Percoset) Hydromorphe (Dilaudid) Fentanyl (Duragesic) or any other? ***Please give details***

3. **Do you currently or have had any cancer?** ☐ **NO** ☐ **YES**

4. **Are you currently experiencing or any sign of past kidney or organ issues?** ☐ **NO** ☐ **YES**
Please *give details*

5. **Are you currently experiencing or any sign of past respiratory issues?** ☐ **NO** ☐ **YES**
(such as; severe asthma, sleep apnea, chronic bronchitis, emphysema, cystic fibrosis or any other) **Please *give details***

6. **Are you currently experiencing or any sign of past heart issues?** ☐ **NO** ☐ **YES**
(such as; arrhythmia, heart disease, congenital heart defects or any other). ***Please give details***

7. **Blood Pressure** *(If yes please tick and add reading if you know)* ☐ **NO** ☐ **YES**

☐ **High**		☐ **Low**	

8. **Do you have Diabetes?** ☐ **NO** ☐ **YES**
☐ Type 1 or ☐ Type 2 - How does this affect you?

9. Are you currently experiencing or any sign of past liver issues? ☐ NO ☐ YES

(such as; cirrhosis, fatty liver disease, fibrosis, autoimmune conditions, Wilson's disease or any other) ***Please give details***

10. Is there any neurological impairment? ☐ NO ☐ YES

(dementia, Alzheimer's disease, Epilepsy, Migraines, Parkinson Disease, multiple sclerosis) ***Please give details***

11. Is there any type of Psychosis, Schizophrenia, Depression, multiple personality disorder? ☐ NO ☐ YES

Please give details

12. Have you or are you currently using Antipsychotics? ☐ NO ☐ YES

Risperidone, Olanzapine, Quetiapine, Ziprasidone, Aripiprazole, Paliperidone, Lurasidone or any other? ***Please give details***

13. Have you had the Corona Vaccination? ☐ NO ☐ YES

☐ Moderna ☐ Astra Zeneca ☐ Johnson & Johnson ☐ Pfizer ☐ Other

If yes above, please select and enter date taken

☐ Vaccination dose #1		☐ Vaccination dose #2	

Signature _____ *Signature of the Person Submitting this Form*

Name _____ *Name of the Person Submitting this Form (print)*

Date of Signature _____ *MM* _____ *DD* _____ *YY*