



Health History Questionnaire

Important: Complete this questionnaire as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a major role in diagnosis and treatment. All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Date: _____

Patient Information

Patient Name

Sex

Date of Birth: (mm/dd/yyyy)

Age

Country

Email Address

Relationship Status

Current Occupation

Contact Number

Contact Number of

Family Member

(mention here the contact number of a person for emergencies)

Cusco Hostel/Hotel Address

Type of San Pedro Retreat



Personal Health History

Childhood Illness: Measles Mumps Rubella Chicken Pox Polio
 Rheumatic Fever

Others:

Medical Illnesses:

Illness:	Age at Onset:	Illness:	Age at Onset:
<input type="checkbox"/> Diabetes	<input type="text"/>	<input type="checkbox"/> Osteoarthritis	<input type="text"/>
<input type="checkbox"/> Hypertension	<input type="text"/>	<input type="checkbox"/> Gout	<input type="text"/>
<input type="checkbox"/> Heart disease	<input type="text"/>	<input type="checkbox"/> Epilepsy	<input type="text"/>
<input type="checkbox"/> Asthma	<input type="text"/>	<input type="checkbox"/> Bleeding disorder	<input type="text"/>
<input type="checkbox"/> Cancer	<input type="text"/>	<input type="checkbox"/> Severe infections	<input type="text"/>
<input type="checkbox"/> Genetic defects	<input type="text"/>	<input type="checkbox"/> Bipolar	<input type="text"/>
<input type="checkbox"/> Venereal disease	<input type="text"/>	<input type="checkbox"/> Surgeries	<input type="text"/>
<input type="checkbox"/> Allergies	<input type="text"/>	<input type="checkbox"/> Others	<input type="text"/>

How much water do you drink daily?

How many caffeinated drinks do you drink per week (coffee, tea, soda)?



Has there been any change in your general health in the past year?

Are you now under a physician's care for a particular problem?

Have you ever had any serious illnesses, operations or hospitalizations? If so please describe

Do you have any cardiovascular disease, including heart attack?

Do you suffer from high blood pressure problem?

Do you suffer from Low blood pressure problem?

Digestion: Please mark below which applies

- Quick ()
- Slow ()
- Normal ()

Do you smoke or chew tobacco?

Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?



Are you on a restricted diet? If so please describe

Have you ever had any psychiatric or psychological diagnostic? If so please describe

Have you ever had any psychiatric or psychological treatment? If so please describe

Are you currently in therapy or do you participate in any kind of support group?

Do you practice meditation, yoga, reiki, bioenergy or any other form of self-exploration? If so, please describe

How do you know about us?

Medications:

List all prescription and over the counter medication, herbs and vitamins that you have been taking on a regular basis in the last 3 months, and the date last taken.

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Name

Frequency

Date



Allergies:

List name of medicine or food that have resulted in an unfavorable reaction. State reaction.

Medications:

Food:

Surgeries & Accidents:

Have you ever had any surgeries or accidents?

Please explain:

Traumas / Abuse:

Have you ever had any traumas or physical or emotional abuse?

Please explain:

Please note that you may choose to discuss this question in a private conversation with Healing Tree Center Staff instead



Family Health History

Do any of your family member suffer from high blood pressure problem? (This question is asked to know high BP history of family)

Do any of your family member suffer from low blood pressure problem? (This question is asked to know low BP history of family)

Do any of your family member suffer from diabetes? (This question is asked to know diabetes history of family members)

Are there people in your family with a history of psychiatric disorders?

Are your parents still alive? Yes: No:

How was your relationship with them in the past?

How is your relationship with them now?

Do you have siblings (Half/Step/Full)? Yes: No:

If yes, how many of each? Brothers: Sisters:

How was/ is your relationship with them in the past, and now?



Is there any specific piece of medical related information which you would like to add? (This question is asked to take any additional information)

Have you ever used any type of drugs? If so please describe

How long ago?

Marijuana/Cannabis..... Yes No

Mushrooms..... Yes No

Nicotine..... Yes No

Alcohol..... Yes No

Anphetamines..... Yes No

Valium..... Yes No

Cocaine..... Yes No

Heroine..... Yes No

Mezcaline..... Yes No

Crack..... Yes No

Ketamine..... Yes No

Ecstasy (MDMA)..... Yes No

LSD..... Yes No

Others:



For women only:

Are you pregnant, or is there any chance you might be pregnant? If so you are not able to participate in the San Pedro ceremony. Yes No

Regular menstrual cycle? Yes No

Describe:

Birth control: If so please describe type.

What are your goals for the San Pedro retreat?

I understand the importance of a truthful and complete health history to assist to The Healing Tree Center in providing the best care possible.

Patient Signature: _____

RELEASE OF LIABILITY



The Client, being at least 18 (eighteen) years of age, in their signature following has requested to participate in a ceremony/retreat of Ayahuasca / San Pedro with The Healing Tree Center and their respective representatives, for which they will have signed this Liability and Authorization Form, and are in full awareness of the risks of such.

The Client states that they have answered their Health History Questionnaire truthfully and completely and are free from any known or unknown heart, physical, mental, drug or any other health problems that could prevent them from participating or cause complications during their participation. They agree that their safety is primarily dependent upon taking proper care of themselves during the Ayahuasca / San Pedro retreat /ceremony, and in following all pre and post Ayahuasca / San Pedro ceremony / retreat, dietary and health guidelines. Clients should consult their health care providers prior to starting any new healing activity/program.

I, the undersigned participant, am freely signing this agreement. I have read this form and fully understand that by signing this form I understand that participation in a ceremony / retreat of Ayahuasca / San Pedro might present a risk of injury or harm to myself, and I agree that this risk is fully borne myself, the Client. In addition, I hereby releases and agree to waive liability, from and against any and all damages and claims of any kind, known or unknown, that may be connected, are the result of, or arising from consideration, preparation, implementation or participation in the aforementioned ceremony/retreat of Ayahuasca /San Pedro, against The Healing Tree Center. This includes, but is not limited to, claims involving economic loss, illness or medical condition, injury or accidental death. I acknowledges having read and understood this Release of Liability. I, the Client, agree with this Release of Liability and precisely express full understanding and it has not been modified orally or in writing.

READ BEFORE SIGNING

The Client

NAME: _____ SIGNATURE: _____ DATE: _____

The Healing Tree Center Representative

NAME: _____ SIGNATURE: _____ DATE: _____

The Healing Tree Center - Patient Policies



Booking Policy

To ensure optimum focus and personalized care and attention for our patients, we set limits on the number of patients we treat at any given time. Retreats are booked on a first-come first-served basis. Bookings are secured / confirmed only upon receipt of a 50% deposit. Once a deposit has been made, you will receive a confirmation email guaranteeing your reservation for your preferred dates. The remaining 50% will be collected the day of your volcanic water cleanse. Retreats will not commence unless complete payment has been made in full prior to the retreat start date.

Payment Policy

The Healing Tree Center accepts payment in US Dollars and Peruvian soles at a set exchange rate (3.4%).

Deposits to secure your booking can be made via:

Paypal - in USD to thehealingtreecenter@gmail.com. Payments are to include a 6.5% Paypal processing fee.

Western Union – <https://www.westernunion.com> in USD to the payee: Italo Jesus Ponce Lopez, and by emailing the Money Transfer Control Number (MTCN) of the payment to thehealingtreecenter@gmail.com

Bank Transfer – in USD to BCP Bank. Payments are to include a \$22 USD bank processing fee. Account Number 002-285-3815-6814-1-02-55. Address: Avenida El Sol #189, Cusco, Cusco, Cusco, Peru (the word 'Cusco' repeated this way is not a mistake). Swift Code: BCPLPEPL

Missed Bookings / Cancellation Policy

Our goal is to provide quality individualized shamanic medical care in a timely manner. We try to be as flexible as possible and accommodate our patients schedules and we will accept short-notice bookings as long as sufficient time is available for patients to perform their pre-retreat preparations. All bookings and or cancellations must be confirmed in writing (email). Verbal notice is not valid.



Missed bookings and cancellations create inconvenience to our staff, shamans, and prevent the scheduling of other patients. We understand situations arise when patients may need to make changes prior to their scheduled booking starting, and advance notice helps us be respectful of our staff and shamans schedules and allows us to be considerate of other patients who would like to book with us. If cancellations occur more than 30 days of securing a reservation / booking, the full 50% deposit will be reimbursed; if 15 – 29 days in advance, 30% of the deposit will be reimbursed; if 5-14 days in advance, 50% of the deposit will be reimbursed; 4 days or less before your reservation, no reimbursement will be provided. No refund will be provided should cancellations occur once the retreats have commenced. In the case of rescheduling retreats/ceremonies for situations that arise that are outside of The Healing Tree Center's responsibility / control, if notice is received within an acceptable notice period, patients may reschedule their booking to a time more convenient for them based on the Center's availability.

Patient Responsibilities

Communication:

We require patients to be completely honest when completing their health questionnaire, especially regarding drug or medication use, and trauma history so that we can ensure patient safety and a complete diagnosis. The Healing Tree Center is a supportive and judgment-free zone, but for patient safety we reserve the right to refuse treatment to patients with the following conditions: pregnancy, heart surgery /pacemakers, mental illness (e.g. schizophrenia, bipolarism), blood disease.

We request respectfully that patients voice any questions or queries about our services without delay so we may assist them in a timely manner.

Openness & Respect:

We request that patients start their journey with: commitment, respect, an open mind, and an open heart.

Confidentiality:

Every patient's journey is private and specific to them. Different groups of patients may be present at the same time at our center for retreats depending on our booking availability. At The Healing Tree Center all patient records are maintained in a confidential manner, and for this purpose we cannot provide personal contact



information. We request that patients be respectful of other persons needs, privacy and journeys. This includes being respectful of other patients requests and personal preferences for private spaces, or minimal or no contact post-retreat. We do take group photos at the end of the retreats so as not to interfere with patients treatment and to respect its sacredness. Photos are used to document patient activities and are used anonymously in The Healing Tree Center's promotional material, and by signing this patients agree to allow The Healing Tree Center to use any photos for these purposes.

READ BEFORE SIGNING

The Client

NAME: _____ SIGNATURE: _____ DATE: _____

PASSPORT NUMBER: _____

The Healing Tree Center Representative

NAME: _____ SIGNATURE: _____ DATE: _____