Thank you for your interest in treatment options. By providing information about you, we will be able to judge whether our treatment program is appropriate to suit your personality and particular health needs. Please answer all questions as accurately as possible, paying special attention to medical and substance use profiles. Incomplete or false information can lead to unintended consequences that may greatly affect your treatment and may result in serious harm. Thank you for your honesty.

Information you provide here is held to the same standards of confidentiality as our therapy. It is recommended but not obligatory to get a few medical tests to ensure the good health of your heart and liver. The blood work is the CMP test (Comprehensive Metabolic Panel), and includes the bilirubin, ALT, AST and ALP. The other test is an EKG graphed with a 12 lead read-out. There will be a sinus diagnosis and readings for the QT, etc. at the top of the page.

You can email the completed form as a pdf file, to bettecorsan@gmail.com Please bring a hard copy of this form with you for treatment, and also bring your test results.

General information

Name:

Address:

Country:

Postal or Zip Code:

E-mail address:

Phone Numbers: cell_____ home_____

Home: OK to call you here? Yes / No
Cell: OK to call you here? Yes / No

Date of Birth:

Nationality:

Do you have a valid passport?

What is your gender? Female / Male / Other

Emergency Contact: Phone:

Relationship to you:

General Health information

Weight: kg or lbs. Recent weight gain or loss: Yes / No

Height: cm or ft.&in.

Current health issues:

Medical History

Please circle or highlight all that apply. Expand below if necessary:

Emphysema
Asthma
Headaches
Obesity
Lung disease
Stomach problems
Hepatitis A Hepatitis B Hepatitis C
Tuberculosis
Allergies
Urinary problems
HIV positive
Heart Disease
Diabetes
Anemia
Gallbladder Disease
Ulcers
Cancer
Migraines
Post-Traumatic Stress Disorder
Nausea, heartburn
Prostate Trouble
Arthritis
Stroke or history of seizures
Alcohol or Substance Use Problem
Back problems

Pneumonia
Heart Disease
Low blood pressure
Bulimia
Elevated Cholesterol
Venous Thrombosis
Bronchitis
Bleeding
Liver Disease
Anorexia
High Blood Pressure
Bowel problems
Cirrhosis
Thyroid Trouble
Frequent Urinary Tract Infections
Osteoporosis
Depression
Renal Disease
Dizzy spells
Sexually Transmitted Infections
Fractures
Anxiety or Panic Disorder
Joint pain, numbness, nerve damage
Shortness of Breath

Other

How would you characterize your overall physical condition?

Statement of Need:

Please provide a brief description of your reasons for seeking treatment at this time.

How have these concerns evolved over time?

What are your spiritual beliefs or practices?

How do you handle emotional problems?

Do you have experience with entheogens (psychedelics) or visionary plant medicines?

Where did you grow up?

Please describe your family life.

What is your educational background?

Where do you work?

What is the hardest thing you've ever worked for?

What do you value most in life?

What were the four happiest moments of your life?

What were the four saddest?

Please list your food preferences and restrictions:

Please highlight or circle any of the following challenges that pertain to you:

Anxiety	Sexual Problems	Finances
Self-Control	Work/Stress	Depression
Suicidal Thoughts	Drug/Alcohol Use	Unhappiness
Health Problems	Fears/Phobias	Separation/Divorce
Career Choices	Insomnia	Cutting/Self-Mutilation
Eating Disorders	Relationships	Anger
Religious Matters	Thought Patterns	

History of Care:

Are you currently under medical care? Yes / No If yes, then please explain/ describe

Name of Personal Physician & Phone Number:

May we contact Doctor in case of emergency? Yes / No

Please explain and describe any current medications you are taking.

List any psychiatric/mental health medications you have taken.

Have you been under the care of a psychiatrist, psychologist, or counsellor? Yes / No

If yes, please give the name and date of the therapy and briefly explain the nature of the problem that required attention.

Have you ever been hospitalised for a mental health condition? Yes / No
If yes, please give the date and briefly explain the nature of the problem that required attention:

Have you ever been in a drug or alcohol treatment program? Yes / No
If yes, please explain the treatment program, length of time in treatment and outcome:

Do you currently drink alcohol? Yes / No How much? How often?

Do you currently smoke tobacco? Yes / No How much? How often?

Do you currently use recreational drugs? Yes / No How often?
What substances?

Do you feel you have a problem with either alcohol or prescription or recreational drugs? Yes / No

Have you ever attempted or considered suicide? Yes / No If yes, please provide some details:

Do you or have you engaged in cutting behaviors? Yes / No
If yes, provide comments or thoughts:

Is there anything else we should know about you?

Your personal information will be held in the strictest confidentiality. We do, however, ask that you allow us to use the above info. and any other data gathered during your treatment for research purposes. None of your personal information will be associated with this data. Any information that can be added to the growing knowledge base for Iboga Art Therapy Research , will lead one step closer to the legitimisation and legalisation of this very important medicine, worldwide.

Do you understand that therapeutic doses of iboga causes ataxia, vomiting, loss of appetite and sometimes temporary sleeplessness and are you prepared to accept some discomforts to obtain the benefits of the medicine?

Yes / No

Do you further agree to give all drugs and medications you have with you, to your treatment provider, understanding that failing to do so may lead to serious consequences and even death?

Yes / No

Do you agree to abstain from your electronic communications devices until advised by your provider to do so?

Yes / No

I, _____, being of sound mind and body have chosen to work with Iboga medicine under the guidance of Bette Corsan. I am fully aware of the risks involved and understand there is no guarantee to the outcome of my experience. I take 100% full responsibility for my choice to ingest this medicine and have asked Bette Corsan to take care of me during the experience. I was advised of the recommended tests for the heart and liver. If I have not provided those results, it is my sole responsibility to ensure the health of both my heart and liver. I agree that this is an in-patient process and acknowledge and understand that my immediate desires after the experience may not be best undertaken in the timing I desire. I therefore agree that I will remain on location and under the care of Bette Corsan for my entire stay until _____. Signed at the Living Life Shamanic Healing location at _____.

(This form needs to be signed at arrival of treatment location) I have completed this form truthfully.

Name: (pleases print) _____

Signature: _____

Date: _____(d/m/y)