**Center for Health & Wellness**


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**Patient Information**

Date _____

Name _____

Address _____ City _____ State _____ Zip Code _____

Home Phone (____) _____- _____ Cell (____) _____- _____

Email _____

Date of Birth _____/_____/_____ Place of birth _____ Gender: Female ____ Male ____

Referred by: _____

Name of primary care physician: _____

Height:_____ Weight:_____

Marital Status:

Single _____ Married _____ Divorced _____ Widowed _____

Emergency Contact:

_____

*Name* *Relationship* *Phone*

Occupation

_____

Genetic Background: Please check appropriate box(es):

- ☐ African American
- ☐ Native American
- ☐ Hispanic
- ☐ Caucasian
- ☐ Mediterranean
- ☐ Northern European
- ☐ Asian
- ☐ Other

Comprehensive Health History

Thank you for choosing our office to assist you with improving your health. Our ability to draw effective conclusions about the state of your health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health is influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will enable us to provide you with an optimal, personalized plan of health care, ensure efficiency, and provide effective use of your scheduled time.

What is your chief concern? _____

What are your goals for your health/life? _____

What are your current symptoms or problems? _____

What are three factors in your life that seem most important to your daily health?_____
_____

Are there any other healers, helpers, or therapies with which you are involved? _____
_____

**Past Medical & Surgical History**
(Include illnesses & injuries)

_____
_____
_____

Do you have any areas of scarring? _____

**Allergies**
(Include allergies to medication, food, or environments)

_____
_____

**Medications**
(List all medications, vitamins, minerals, and nutritional supplements that you are currently taking)

_____
_____

**Childhood History**

| | Yes | No | Don't know | Comment |
|---|---|---|---|---|
| Were you a full term baby? | | | | |
| Premature birth? | | | | |
| Breast fed? | | | | |
| Bottle fed? | | | | |

**Lifestyle History**

Tobacco Use? Yes _____ No_____ If yes, number of years? _____ If not a current user, year quit? _____

Alcohol Intake? Yes _____ No _____ If yes, how often?

- No longer drink alcohol
- Average 1-3 drinks per week
- Average 4-6 drinks per week
- Average 7-10 drinks per week
- More than 10 drink per week

Recreational Drugs? Yes _____ No _____ If yes, what type? _____

**Sleep & Rest**

Average number of hours that you sleep at night? _____

Do you:

- Have trouble falling asleep?
- Have trouble staying asleep or awaken through the night? If so, approximately what time do you awaken through the night? _____
- Do you use sleep aids?
- Have insomnia?
- Feel rested upon awakening?
- Do you dream? If so, do you remember any? _____

**Exercise**

Do you exercise regularly? Yes _____ No_____ If yes, what type of exercise do you engage in? _____

How often and duration of session? _____

## Female Health History

Date of last menstrual period? _____
Are your periods regular? _____ Frequency? _____
Length of menstruation? _____
Painful or symptomatic periods? _____
Are you menopausal? Yes _____ No _____ If yes, age of menopause _____
When was your last pap smear? _____ Normal:_____ Abnormal:_____
Number of pregnancies _____ Deliveries _____ _____
Abortions _____Miscarriage _____Other_____
Do you currently use contraception? Yes _____ No _____ If yes, what form? _____
Date of last thermography or mammogram _____ Breast biopsy date _____

Please advise of symptoms that you feel are significant _____
_____
_____

Names of Children:

| *Name* | *Sex* | *Birthdate* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Men's Health History

Have you had a PSA test performed? Yes _____ No _____ If yes, what were the levels? _____

Check if you have or have had the following:

- ☐ Prostate enlargement
- ☐ Testicular lumps
- ☐ Sores on penis
- ☐ Hernia
- ☐ Decreased libido
- ☐ Impotence
- ☐ Infertility/low sperm count
- ☐ Difficulty maintaining an erection
- ☐ Prostate cancer
- ☐ Nocturia (urination at night)
- ☐ Urgency/hesitancy/changes in urinary stream
- ☐ Loss of bladder control

**General Questions**

Are you overall happy? Yes _____ No _____

Do you feel you can handle the stress in your life? Yes _____ No _____

If no, do you believe stress is reducing the quality of your life? Yes _____ No _____

If yes, do you know the source of your stress? Yes _____ No _____

If yes, what do you believe it to be? _____

Are you able to express your emotions/feelings? Yes _____ No _____

Is there an emotion you feel predominantly? Anger _____ Sadness/Depression _____ Fear _____ Worry _____ Excessive Joy _____ Other _____

Are you too emotional or too unemotional? _____

Are you happy with your general energy level?_____

Is there a low point in your day? Yes _____ No _____ If yes, when? _____

Do you have a favorite time of day? _____

Do you have a favorite climate/weather? _____

Are there climates you especially do not like? _____

What is your favorite color? _____

What is your favorite season? _____

What level did you complete in school? _____

Any organized life/trade training? _____

What, if any, was your military service? _____

With whom do you live? _____

Relationships? _____

What is your career? _____

What are your hobbies/pleasures? _____

What are your indulgences, and how often? _____

Have you ever abstained or "quit" anything? Yes _____ No _____ If yes, what was it and how long did you abstain from it? _____

Do you crave that from which you have abstained_____

How do you feel about yourself? _____

How do you feel about your life? _____

Do you have any pets? _____

# Health Survey/Concerns

Check (√) the items that apply to you.

## SKIN

- ☐ Cuts heal slowly
- ☐ Bruise easily
- ☐ Rashes
- ☐ Pigmentation
- ☐ Changing moles
- ☐ Calluses
- ☐ Eczema
- ☐ Psoriasis
- ☐ Dryness/cracking skin
- ☐ Oily skin
- ☐ Itching
- ☐ Acne
- ☐ Boils or skin lesions
- ☐ Hives
- ☐ Nail fungi
- ☐ Peeling skin
- ☐ Shingles
- ☐ Nails Split
- ☐ White spots/Lines on nailbed
- ☐ Crawling sensation
- ☐ Burning on bottom of feet
- ☐ Athletes foot
- ☐ Cellulite
- ☐ Bugs bites
- ☐ Bumps on back of arms & front of thighs
- ☐ Skin cancer
- ☐ Body odor

Is your skin sensitive to:

- ☐ Sun
- ☐ Fabrics
- ☐ Detergents
- ☐ Lotions/Creams

## HEAD

- ☐ Poor Concentration
- ☐ Confusion
- ☐ Headaches:
- ☐ Concussion/Whiplash
- ☐ Mental Sluggishness
- ☐ Forgetfulness
- ☐ Indecisive
- ☐ Facial twitching
- ☐ Poor memory
- ☐ Hair loss

## EYES

- ☐ Gritty sensation in eyes
- ☐ Double vision
- ☐ Blurred vision
- ☐ Poor night vision
- ☐ See bright flashes
- ☐ Halo around lights
- ☐ Eye pains
- ☐ Dark circle under eyes
- ☐ Strong lights irritate eyes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Visual hallucinations
- ☐ Discharge
- ☐ Conjunctivitis

## EARS

- ☐ Aches
- ☐ Ringing
- ☐ Deafness/Hearing loss
- ☐ Itching
- ☐ Pressure
- ☐ Frequent Infections
- ☐ Tubes in ears
- ☐ Sensitivity to loud noises
- ☐ Auditory hallucinations

## Nose/Sinuses

- ☐ Congested
- ☐ Running/discharge
- ☐ Post nasal drip
- ☐ Nasal polyps
- ☐ Nosebleeds
- ☐ Loss of sense of small
- ☐ Do seasonal changes tend to make your symptoms worse? Yes/No

## Mouth

- ☐ Teeth problems
- ☐ Bleeding/swollen gums
- ☐ Dry mouth
- ☐ Bad breath
- ☐ Coated tongue
- ☐ Canker sores
- ☐ TMJ
- ☐ Cracked/chapped lips
- ☐ Root canal
- ☐ Dentures

## Throat

- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Tonsillitis
- ☐ Constant clearing of throat
- ☐ Mucus

## Kidney/Urinary Tract

- ☐ Frequent urination
- ☐ Burning upon urination
- ☐ Painful urination
- ☐ Nocturia (night time urination)
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Bladder infections (cystitis, etc.)
- ☐ Bedwetting

## Circulation/Respiration

- ☐ Edema (swollen limbs)
- ☐ Numbness/Tingling in hands or feet
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Pain between shoulders
- ☐ Dizziness upon standing
- ☐ Fainting spells
- ☐ Irregular heartbeat
- ☐ Night sweats
- ☐ Emphysema
- ☐ COPD
- ☐ Asthma
- ☐ Heart murmur
- ☐ Frequent upper or lower respiratory tract infection
- ☐ Prior heart attack

  Date_____

## Gastrointestinal

- ☐ Peptic/Duodenal Ulcer
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Gallstones
- ☐ Abdominal pain
- ☐ Indigestion/heartburn
- ☐ Hernia
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Changes in bowel habit
- ☐ Rectal bleeding
- ☐ Rectal itching
- ☐ Bloating
- ☐ Gas
- ☐ Bloody or tarry stools
- ☐ Anal fissure

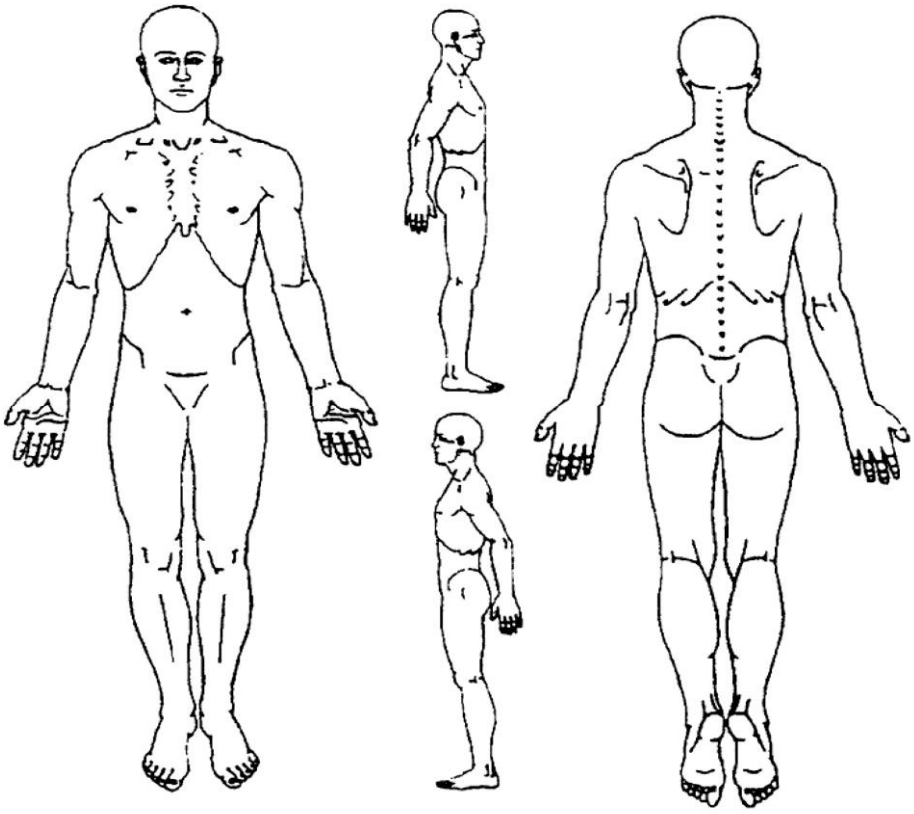
# Pain Assessment

**Draw the location of your pain on the figures below using the following symbols:**

| Ache | Numbness | Pins and Needles | Burning | Stabbing | Other |
|---|---|---|---|---|---|
| ^^^^^ | OOOOO | . . . . . | = = = = = | / / / / / / | XXXX |

**Pain Severity Scale: Rate the severity of your pain by checking one box on the following scale**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|



Patient Signature:_____Date:_____