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Wellness Intake

First Name _____ Middle Initial ___ Last Name _____

Address_____ Home Phone _____ Cell Phone _____

City _____ State ____ Zip _____ Sex M ___ F ___

Email _____ May we send your billing to this Email? Yes___No___

Birth date _____ Single ___ Married ___ Widowed ___

Patient Employed by _____ Occupation _____

Whom may we thank for referring you? _____

Insurance: Yes___No___ Policy Holder_____ Relationship _____

Emergency Contact: _____ Relationship _____ Phone _____

Is your visit today related to an accident? ☐ Yes ☐ No

If yes: ☐ Auto Accident ☐ Sports Related ☐ Work Related ☐ Other

If accident related: Date of Injury: _____

What health problem brought you to us today? _____

This problem is ☐ Worsening ☐ Staying the Same ☐ Improving

Global Health Scale: Rate your general well-being

Poor 0 _____5_____10 Good

We tend to ignore symptoms until they are so bad we cannot stand them anymore. Please check the box next to any symptoms you have now, or have experienced in the last 6 months:

Head:

- ☐ Headache:
  - ☐ Whole head
  - ☐ Back of Head
  - ☐ Top of Head
  - ☐ Forehead
  - ☐ Temple R L
  - ☐ Migraine
- ☐ "Heavy" Head
- ☐ Memory Loss
- ☐ Hearing Loss
- ☐ Pain in Ears
- ☐ Smell Loss
- ☐ Taste Loss
- ☐ Balance Loss
- ☐ Eye Pain
- ☐ Light Sensitivity
- ☐ Blurred Vision
- ☐ Fainting
- ☐ Lightheaded
- ☐ Dizziness
- ☐ Ear Ringing
- ☐ Ears Buzzing
- ☐ Facial Pain R L
- ☐ Teeth Pain

Name: _____

Neck:
- ☐ Neck Pain
- ☐ Movement Pain
- ☐ Feels Out
- ☐ Neck Stiff
- ☐ Muscle Spasm
- ☐ Neck Grinds
- ☐ Difficulty Swallowing
- ☐ Popping
- ☐ Nerve Feels Pinched

Shoulders / Arms:
- ☐ Shoulder Pain R L
- ☐ Across Shoulder Pain
- ☐ Cannot Lift Arm Above Shoulder Level
- ☐ Can't Lift Arm Over Head
- ☐ Nerve Pain Shoulder R L
- ☐ Shoulder Spasm
- ☐ Tense in Shoulder
- ☐ Pain Arm R L
- ☐ Pain Forearm R L
- ☐ Pains Hand R L
- ☐ Pain Wrist R L
- ☐ Pains Fingers R L
- ☐ Hand Cold R L
- ☐ Hand Swollen R L
- ☐ Arthritis Fingers R L
- ☐ Arthritis Hand R L
- ☐ Weak Grip Hand R L
- ☐ Carpal Tunnel R L

Mid Back / Chest:
- ☐ Mid Back Pain
- ☐ Pain Between Shoulder Blades
- ☐ Spasms Mid Back
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Pain in Ribs
- ☐ Pain in Left Ribs

Low Back:
- ☐ Low Back Pain:
  - ☐ When working
  - ☐ When Lifting
  - ☐ When Stooping
  - ☐ When Standing
  - ☐ When Sitting
  - ☐ When Bending
  - ☐ When Coughing
  - ☐ When Lying down
- ☐ Low Back Out
- ☐ Muscle Spasms
- ☐ Arthritis

Abdomen:
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Menstrual Pain
- ☐ Cramping
- ☐ Irregularity
- ☐ Abdominal Pain

Hips / Legs / Feet:
- ☐ Pain Buttocks R L
- ☐ Pain Hip R L
- ☐ Pain Thigh R L
- ☐ Pain Leg R L
- ☐ Pain Ankle R L
- ☐ Pain Foot R L
- ☐ Cramps Leg R L
- ☐ Numb Leg R L
- ☐ Numb Foot R L
- ☐ Numb toes R L
- ☐ Cold Foot R L
- ☐ Burning Foot R L
- ☐ Cramps Foot R L
- ☐ Swollen Ankle R L
- ☐ Swollen Foot R L
- ☐ Pain in Foot R L
- ☐ Pain in Toes R L

General:
- ☐ Fatigued
- ☐ Teeth Grinding
- ☐ Run Down
- ☐ Insomnia
- ☐ Restless Legs
- ☐ Skin Itches
- ☐ Wake up Exhausted
- ☐ Irritable bowel
- ☐ Asthma or Hay fever
- ☐ Forgetful
- ☐ Foggy Minded
- ☐ Difficulty Breathing
- ☐ Skin Sensitivity
- ☐ Over all Body Pain
- ☐ Nausea
- ☐ Chronic Fatigue

Physiological:
- ☐ Suicidal Feelings
- ☐ Suicidal Plans
- ☐ Suicidal Attempts
- ☐ Depressed
- ☐ Panic Attacks
- ☐ Nervousness
- ☐ Anxiety
- ☐ Irritable
- ☐ Loss of periods of time

How do these activities affect your symptoms?

Activity	Better	Worse
Walking		
Swimming		
Sleeping		
Working		
Lifting		
Bending		
Stooping		
Pulling		
Exercise		
Intercourse		

Name: _____

Demographics

How tall are you: _____ How much do you weigh? _____

Do you know what your blood pressure runs? _____

Do you have a dominant hand? Please circle: Right Left Ambidextrous

Do you consider yourself part of a race or ethnic group? _____

If yes, what race/group? _____

Allergies

Are you allergic to any medications? List allergies to medication (and your reaction to them):

☐ I have no known allergies to medication.
☐ I am allergic to: _____. My reaction is: _____
_____ _____
_____ _____
_____ _____

☐ Additional allergies to medication listed on back

Do you have any other allergies? List your allergies (and your reaction to them):

☐ I have no known allergies.
☐ I am allergic to: _____. My reaction is: _____
_____ _____
_____ _____
_____ _____

☐ Additional allergies listed on back

Sleep

Healing occurs when you are asleep, and sleep is essential for proper immune system function. The following questions are about your sleep patterns:

How many hours do you sleep each day? _____

How many hours do you spend in bed each day? _____

Please rate the quality of your sleep:

I wake up as tired as when I went to bed. I wake up refreshed and ready to go.
0 _____5_____10

Do you wake up during the night? Y N If yes, how many times, on average? _____

If you wake up, is it generally at a particular time, no matter when you go to sleep? Y N

If yes, what time(s) do you wake up? _____

Childhood Trauma

We know that health problems can come from biochemical imbalances due to poor nutrition or toxicity, hormone imbalances from stress or neurological problems from trauma. The average child has at least 1,000 traumas by the age of 13. Please answer the following questions about your childhood traumas (things like concussions and broken bones go in the next section):

Were you accident prone? Y N

How many times a week do you think you fell down while running around? _____

Did you ever:

Physically roughhouse with brothers, sisters, friends or others? Y N
If so, how many times a week? ____ For how many years? _____

Fall off your bike? Y N
If so, how many times a week? ____ For how many years? _____

Play sports, like football, skiing, hockey, etc.? Y N
If so, how many times a week? ____ For how many years? _____

Read with your neck flexed for more than two hours at a time? Y N
If so, how many times a week? ____ For how many years? _____

Have pillow fights? Y N
If so, how many times a week? ____ For how many years? _____

Participate in gymnastics, dance, or cheerleading? Y N
If so, how many times a week? ____ For how many years? _____

Were you in any auto accidents? Y N
If so, how many? ____ At what ages?_____

Other Traumas

Traumas continue to occur in most of our lives. These may include bad falls, broken bones, and blows to the head throughout our lives and injuries at work and auto accidents as an adult, all of which may contribute the neurological problems from trauma.

Please describe any traumatic incidents and give us either the year or your age when the trauma occurred, to the best of your memory. If you need more room, please check the box and continue on the back of this page.

	Incident	Year/Age
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

☐ Additional traumas listed on back

One common trauma that we often overlook is from elective or emergency surgery. The scar tissue that results may cause or contribute to many of our structural problems.

Please list any surgery you have had, what it was for, and either the year or your age when the surgery happened. If you need more room, please check the box and continue on the back of this page.

	Surgery	Reason	Year/Age
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

☐ Additional surgeries listed on back

Medications AND Supplements

Medications (prescribed and over the counter) as well as herbal and nutritional supports that are not correct for you can be contributing to the health problems that arise from biochemical imbalances due to poor nutrition or toxicity. Please list:

- The medications and other herbal and nutritional supports you are currently taking.
- The condition for which you are taking it.
- The dosage and frequency. If prescribed 'as needed', estimate and record the amount taken per week, month or year.
- We do need ALL of this information. If you have this information already prepared to hand to doctors, make sure the information is current, make us a copy, give it to us when you turn in this form, and write 'See attached' in the first blank.
- Place a NA in the first blank if you do not take any medications or nutritional supports.

Medications/Supplement	Taken For	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

☐ Additional medication/supplements listed on back

Habits

Some of our habits can also contribute to the health problems that arise from biochemical imbalances due to poor nutrition or toxicity. Please choose the correct responses below:

Tobacco:

Never Used Tobacco:

- ☐ Never used tobacco in any form

Ex-User:

- ☐ Ex-very heavy cigarette smoker (40+/day)
- ☐ Ex-heavy cigarette smoker (20-39/day)
- ☐ Ex-moderate cigarette smoker (10-19/day)
- ☐ Ex-light cigarette smoker (1-9/day)
- ☐ Ex-trivial cigarette smoker (<1/day)
- ☐ Ex-pipe smoker
- ☐ Ex-cigar smoker
- ☐ Ex-user tobacco as chew or snuff

Tobacco User:

- ☐ Chews fine cut tobacco Chews loose leaf tobacco
- ☐ Chews plug tobacco
- ☐ Chews products containing tobacco
- ☐ Chews twist tobacco
- ☐ Snuff user

Smoker:

- ☐ Chain smoker
- ☐ Very heavy cigarette smoker (40+ cigs/day)
- ☐ Heavy cigarette smoker (20-39 cigs/day)
- ☐ Moderate cigarette smoker (10-19 cigs/day)
- ☐ Light cigarette smoker (1-9 cigs/day)
- ☐ Trivial cigarette smoker (less than one cigarette/day)
- ☐ Pipe smoker
- ☐ Cigar Smoker

Started smoking in: _____ Stopped smoking in: _____

Alcohol:

- ☐ I consume alcohol ☐ daily ☐ occasionally.
  - ☐ I drink ☐ wine ☐ beer ☐ mixed drinks/cocktails ☐ other
  - ☐ _____ (# or amount) per ☐ day ☐ week ☐ month
- ☐ I do not use alcohol.

Fast/Convenient Food:

- ☐ I am a fast food/restaurant user.
  - ☐ I eat _____ meals not prepared at home every ☐ day ☐ week ☐ month
- ☐ I am a convenience food user.
  - ☐ I eat _____ meals where a significant portion is from a box, bag or prepared and preserved by a manufacturer every ☐ day ☐ week ☐ month

Beverages:

I am a coffee drinker. I drink _____ (#) _____ (ounce) cups of coffee per day.

- ☐ I drink ☐ regular coffee ☐ decaffeinated coffee
  - ☐ Black ☐ with cream ☐ with cream and sugar ☐ with flavoring
  - ☐ From the espresso stand.

I am a tea drinker. I drink _____ (#) _____ (ounce) cups/glasses of tea per day.

- ☐ I drink ☐ regular tea ☐ decaffeinated tea ☐ herbal tea
  - ☐ Unsweetened ☐ sweetened with _____

I am a carbonated beverage drinker.

- ☐ I drink _____ ounces per ☐ day ☐ week of
  - ☐ _____ (name of preferred drink) ☐ regular ☐ diet

I drink water. I drink _____ (#) _____ (ounce) cups/glasses of water per day.

- ☐ I drink water directly from my tap. ☐ I have softened water in my home.
- ☐ I treat tap water at home before I drink it by
  - ☐ A filter ☐ pitcher ☐ on my faucet ☐ in my refrigerator door ☐ multistage
  - ☐ Reverse osmosis
  - ☐ Distilling. ☐ I add minerals to the distilled water that I drink.
- ☐ I drink bottled water I purchase
  - ☐ in single serving soft plastic bottles ☐ in 5 gallon hard plastic bottles.

Occupational Exposures

We often overlook our exposure to toxic chemicals, which often contribute to the health problems that arise from biochemical imbalances due to toxicity.

Please reflect back on all of the jobs that you have done, even as a youngster. Were you exposed to pesticides, herbicides, petroleum products, chemicals, dyes, dust or fumes?

Describe your toxic exposures, the length of time you were exposed, and your age when the exposure occurred, to the best of your memory. If you need more room, please check the box and continue on the back of this page.

Exposure	How long?	Year/Age
1.		
2.		
3.		
4.		

☐ Additional exposures listed on back

Activities of Daily Living

The symptoms you are experiencing now may be affecting how well you are able to participate in the activities of your daily life. Please check anything being affected by your current state of health:

- ☐ Seeing
- ☐ Reading
- ☐ Writing
- ☐ Hearing
- ☐ Tasting
- ☐ Smelling
- ☐ Eating
- ☐ Grooming
- ☐ Bathing
- ☐ Dressing
- ☐ Grasping
- ☐ Pinching
- ☐ Holding
- ☐ Typing
- ☐ Reaching
- ☐ Standing
- ☐ Leaning
- ☐ Walking
- ☐ Stooping
- ☐ Squatting
- ☐ Kneeling
- ☐ Bending
- ☐ Twisting
- ☐ Pushing
- ☐ Pulling
- ☐ Climbing
- ☐ Carrying
- ☐ Lifting
- ☐ Reclining
- ☐ Sitting
- ☐ Exercising
- ☐ Driving
- ☐ Riding in Car
- ☐ Air Travel

Are you experiencing any difficulty with:

- ☐ Concentrating
- ☐ Nervousness
- ☐ Irritability
- ☐ Insomnia
- ☐ Personality Change
- ☐ Using the Toilet
- ☐ Intimate Relationships
- ☐ Participating in Sports

What follows is called a **System Review**. It's looking for anything else that we might have missed. Take just a few more minutes to look at each symptom, and check any that you have experienced in the last year:

Constitutional symptoms
- ☐ Weight loss or gain
- ☐ Fever/Chills
- ☐ Fatigue
- ☐ Malaise (general feeling of being unwell)
- ☐ Night sweats
- ☐ Decreased appetite

Eyes
- ☐ Visual changes
- ☐ Eye pain
- ☐ Double vision
- ☐ Blind spots
- ☐ Floaters**Ear, Nose, Mouth, Throat**
- ☐ Runny Nose
- ☐ Frequent nosebleeds
- ☐ Sinus pain
- ☐ Stuffy ears
- ☐ Ear pain
- ☐ Ringing in the ears
- ☐ Bleeding gums
- ☐ Toothache
- ☐ Pain was swallowing
- ☐ Sore throat

Female Issues
- ☐ Vaginal discharge
- ☐ Vaginal pain
- ☐ Irregular menses

Cardiovascular
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Exercise intolerance
- ☐ Edema
- ☐ Palpitations
- ☐ Faintness
- ☐ Loss of consciousness

Respiratory
- ☐ Cough
- ☐ Wheeze
- ☐ Shortness of breath
- ☐ Exercise intolerance
- ☐ Bloody sputum

Gastrointestinal
- ☐ Abdominal pain
- ☐ Unintentional weight loss
- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ Bloating
- ☐ Cramping
- ☐ Anorexia/Food Avoidance
- ☐ Nausea/Vomiting
- ☐ Diarrhea/Constipation
- ☐ Excessive gas
- ☐ Vomiting blood
- ☐ Bright red blood in stools
- ☐ Dark black tarry stools
- ☐ Feeling of incomplete bowel movement

Urinary
- ☐ Incontinence
- ☐ Painful urination
- ☐ Wake up to void at night
- ☐ Frequent urination
- ☐ Difficult urination
- ☐ Decreased force of stream

Skin, hair, nails
- ☐ Excessive itching
- ☐ Rashes
- ☐ Eczema/psoriasis
- ☐ Nodules/tumors
- ☐ Excessive dryness
- ☐ Discoloration
- ☐ Change in Finger/Toe Nails

Neurological
- ☐ Seizures
- ☐ Faints
- ☐ Fits
- ☐ Funny turns
- ☐ Pins and needles
- ☐ Numbness
- ☐ Limb weakness
- ☐ Poor balance
- ☐ Speech problems
- ☐ Loss of bowel or bladder control

Psychiatric
- ☐ Depression
- ☐ Change in sleep patterns
- ☐ Anxiety
- ☐ Difficulty concentrating
- ☐ Poor body image
- ☐ Poor work or school performance
- ☐ Lack of energy
- ☐ Episodes of mania
- ☐ Episodic change in personality
- ☐ Expansive personality
- ☐ Binges

Endocrine - Hyperthyroid
- ☐ Prefer cold weather
- ☐ Mood swings
- ☐ Infrequent or light menstruation
- ☐ Diarrhea
- ☐ Weight loss despite increased appetite
- ☐ Tremors
- ☐ Palpitations
- ☐ Visual disturbance

Hypothyroid
- ☐ Prefer hot weather
- ☐ Slow, tired
- ☐ Depressed
- ☐ Thin hair
- ☐ Croaky voice
- ☐ Heavy periods
- ☐ Constipation
- ☐ Dry skin

Diabetes
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Constant hunger without weight gain (Type 1)

Hypoglycemia
- ☐ Dizziness
- ☐ Sweating
- ☐ Headache
- ☐ Hunger
- ☐ Slurred speech

Adrenal
- ☐ Difficult to treat hypertension
- ☐ Chronic low light pressure
- ☐ Lightheadedness when rising
- ☐ Darkening of skin in non-sun exposed places

Hematological
- ☐ Prolonged or excessive bleeding
- ☐ Refused for blood donation
- ☐ Anemia
- ☐ Purple or red discoloration of the skin

Immunological
- ☐ Swelling or pain in the groin
- ☐ Swelling or pain in the armpit
- ☐ Swelling or pain in the neck
- ☐ Any Allergic Reaction

Who is your primary care physician? _____ Phone #: _____

When was your last physical? _____

Family Health History	First Name	Year of birth [if known]	Serious illnesses or other medical conditions and age at onset [if known]	If deceased list cause and age at death [if known]
Mother's Family				
Mother				
sibling				
sibling				
Father's Family				
Father				
sibling				
sibling				
Your Family				
You				
sibling				
sibling				
child				
child				

_____ _____ _____

Today's Date Patient's Printed Name Patient's Signature (over 17 years old)

_____

Guardian Signature (under 18 years old)

_____

Guardian Printed Name