**Add your Clinic information here**

Name: Date:

Address:

City: State: Zip Code:

Telephone # (home): (work):

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: Date of Birth: Gender: female male

Education:

Married: \_\_\_\_Separated: Divorced: Widowed: Single: Partnership:

Live with: Spouse Partner \_\_\_\_\_ Parents Children Friends Alone

Occupation: Hours per week: Retired:

Employer: S.S.#:

(Work address):

How did you hear about our clinic?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any other family member already been a patient at the clinic?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin or other to reach in an emergency:

Relationship: Phone:

Address:

**PLEASE FILL OUT BOTH SIDES OF EACH PAGE**

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) Why did you choose to come to this clinic?

* What do you know about our approach?

2) What three expectations do you have from this visit to our clinic?

* What long term expectations do you have from working with our clinic?
* What expectations do you have of me personally as your physician?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Career

Money

Health

Significant Other/ Romance

Fun &

Recreation

Personal

Growth

Family & Friends

Physical

Environment

**Wheel of Balance**

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

Example:

90%

70%

60%

100%

80%

80%

80%

50%

Are you currently receiving healthcare? Y N

If yes, where and from whom:

If no, when and where did you last receive medical or health care?

What was the reason?

What are your most important health problems? List as many as you can in order of importance:

1)

2)

3)

4)

5)

6)

7)

Do you have any known contagious diseases at this time? Y N

If yes, what?

**Family History**

Do you have a family history of any of the following (please circle)?

Cancer Diabetes Heart Disease High Blood Pressure

Kidney Disease Epilepsy Arthritis Glaucoma

Tuberculosis Stroke Anemia Mental Illness

Asthma/Hayfever/Hives

Any other relevant family history?

What is your heritage: German Nordic\_\_\_\_\_\_\_\_ Celtic \_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_

**Childhood Illnesses**

Please circle whether you had any of these as a child:

Scarlet fever Diphtheria Rheumatic fever

Mumps Measles German measles

**Hospitalization, Surgery, Imaging**

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG’s have you had?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_\_\_

**Allergies**

Are you hypersensitive or allergic to...

Any drugs?

Any foods?

Any environmentals or chemicals?

**Current Medications**

Do you take or use?

Laxatives Y N Pain relievers Y N Antacids Y N

Cortisone Y N Appetite suppressants Y N Antibiotics Y N

Tranquilizers Y N Thyroid medication Y N Sleeping pills Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1) 5)

2) 6)

3) 7)

4) 8)

**General**

Height: Weight: lbs. Weight 1 year ago: lbs.

Maximum Weight : When:

When during the day is your energy the best? worst?

**Typical Food Intake**

Breakfast:

Lunch:

Dinner:

Snacks:

To drink:

**FOR THE FOLLOWING, PLEASE CIRCLE**

**Y=**a condition you have now **N=**Never had **P=**Significant problem in the past

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**Habits**

Main interests and hobbies?

Do you exercise? Y N

If yes, what kind? How often?

Average 6-8 hrs. sleep? Y N Enjoy your work? Y N

Sleep well? Y N Take vacations? Y N

Awaken rested? Y N Spend time outside? Y N

Have a supportive relationship? Y N Watch television? Y N

Have a history of abuse? Y N how many hours?

Any major traumas? Y N P Read? Y N

Use recreational drugs? Y N P how many hours? \_\_\_\_\_\_

Been treated for drug dependence? Y N P

Use alcoholic beverages? Y N P Do you eat 3 meals a day? Y N

Treated for alcoholism? Y N P Do you go on diets often? Y N

Do you use tobacco? Y N P Do you eat out often? Y N

Smoked previously? Y N P Do you drink coffee? Y N P

How many years? Drink black/green tea? Y N P

How many packs per day? Do you drink cola/other sodas? Y N P

Do you eat refined sugar? Y N P

Do you add salt? Y N P

Do you have a religious or spiritual practice? Y N If yes, what?

**REVIEW OF SYSTEMS**

**Mental / Emotional**

Treated for emotional problems? Y N P Depression? Y N P

Mood Swings? Y N P Anxiety or nervousness? Y N P

Considered/Attempted suicide? Y N P Tension? Y N P

Poor concentration? Y N P Memory problems? Y N P

**Immune**

Reactions to immunizations? Y N P Reactions to vaccinations? Y N P

Chronic Fatigue Syndrome? Y N P Chronic infections? Y N P

Chronically swollen glands? Y N P Slow wound healing? Y N P

**Y=**a condition you have now **N=**Never had **P=**Significant problem in the past

**Endocrine**

Hypothyroid? Y N P Heat or cold intolerance? Y N P

Hypoglycemia? Y N P Diabetes? Y N P

Excessive thirst? Y N P Excessive hunger? Y N P

Fatigue? Y N P Seasonal depression? Y N P

**Neurologic**

Seizures? Y N P Paralysis? Y N P

Muscle weakness? Y N P Numbness or tingling? Y N P

Loss of memory? Y N P Easily stressed? Y N P

Vertigo or dizziness? Y N P Loss of balance? Y N P

**Skin**

Rashes? Y N P Eczema, Hives? Y N P

Acne, Boils? Y N P Itching? Y N P

Color Change? Y N P Perpetual Hair Loss? Y N P

Lumps? Y N P Night Sweats? Y N P

**Head**

Headaches? Y N P Head Injury? Y N P

Migraines? Y N P Jaw/TMJ problems Y N P

**Eyes**

Spots in Eyes? Y N P Cataracts? Y N P

Impaired vision? Y N P Glasses or contacts? Y N P

Blurriness? Y N P Eye pain/strain? Y N P

Color blindness? Y N P Tearing or dryness? Y N P

Double Vision? Y N P Glaucoma? Y N P

# Ears

Impaired hearing? Y N P Ringing? Y N P

Earaches? Y N P Dizziness? Y N P

**Nose and Sinuses**

Frequent colds? Y N P Nose Bleeds? Y N P

Stuffiness? Y N P Hayfever? Y N P

Sinus problems? Y N P Loss of smell? Y N P

**Mouth and Throat**

Frequent sore throat? Y N P Copious saliva? Y N P

Teeth grinding? Y N P Sore tongue/lips? Y N P

Gum problems? Y N P Hoarseness? Y N P

Dental cavities? Y N P Jaw clicks? Y N P

# Neck

Lumps? Y N P Swollen glands? Y N P

Goiter? Y N P Pain or stiffness? Y N P

**Y=**a condition you have now **N=**Never had **P=**Significant problem in the past

**Respiratory**

Cough? Y N P Sputum? Y N P

Spitting up blood? Y N P Wheezing Y N P

Asthma? Y N P Bronchitis? Y N P

Pneumonia? Y N P Pleurisy? Y N P

Emphysema? Y N P Difficulty breathing? Y N P

Pain on breathing? Y N P Shortness of breath? Y N P

Shortness of breath at night? Y N P “ “ “ lying down? Y N P

Tuberculosis? Y N P

**Cardiovascular**

Heart disease? Y N P Angina? Y N P

High/Low Blood Pressure? Y N P Murmurs? Y N P

Blood clots? Y N P Fainting? Y N P

Phlebitis? Y N P Palpitations/Fluttering? Y N P

Rheumatic Fever? Y N P Chest pain? Y N P

Swelling in ankles? Y N P

**Gastrointestinal**

Trouble swallowing? Y N P Heartburn? Y N P

Change in thirst? Y N P Abdominal pain or cramps? Y N P

Change in appetite? Y N P Belching or passing gas? Y N P

Nausea/vomiting Y N P Constipation? Y N P

Ulcer? Y N P Diarrhea? Y N P

Jaundice (yellow skin)? Y N P Bowel Movements: How often?

Gall Bladder disease? Y N P Is this a change?

Liver Disease? Y N P Black stools? Y N P

Hemorrhoids? Y N P Blood in stool? Y N P

**Urinary**

Pain on urination? Y N P Increased frequency? Y N P

Frequency at night? Y N P Inability to hold urine? Y N P

Frequent infections? Y N P Kidney stones? Y N P

**Musculoskeletal**

Joint pain or stiffness? Y N P Arthritis? Y N P

Broken bones? Y N P Weakness? Y N P

Muscle spasms or cramps? Y N P Sciatica? Y N P

**Blood / Peripheral Vascular**

Easy bleeding or bruising? Y N P Anemia? Y N P

Deep leg pain? Y N P Cold hands/feet? Y N P

Varicose veins? Y N P Thrombophlebitis? Y N P

**Y=**a condition you have now **N=**Never had **P=**Significant problem in the past

**Male Reproduction**

Hernias? Y N P Testicular masses? Y N P

Testicular pain? Y N P Prostate disease? Y N P

Venereal disease? Y N P Discharge or sores? Y N P

Are you sexually active? Y N P Chlamydia? Y N P

Sexual orientation: Gonorrhea? Y N P

Impotence? Y N P Condyloma? Y N P

Premature ejaculation? Y N P Herpes? Y N P

Birth control? Type? Syphilis? Y N P

# Female Reproduction / Breasts

Age of first menses? Date of last annual exam/ PAP

Age of last menses? (if menopausal) Are cycles regular? Y N P

Length of cycle? days Bleeding between cycles? Y N P

Duration of menses? days Pain during intercourse? Y N P

Painful menses? Y N P Clotting? Y N P

Heavy or excessive flow? Y N P Discharge? Y N P

PMS? Y N P Birth control? Y N P

If yes, what are your symptoms? What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_\_

Number of live births: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Endometriosis? Y N P Number of miscarriages: \_\_\_\_\_\_\_\_\_\_\_\_

Ovarian cysts? Y N P Number of abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Difficulty conceiving? Y N P Menopausal symptoms? Y N P

Cervical Dysplasia? Y N P Abnormal PAP? Y N P

Sexual difficulties? Y N P Chlamydia? Y N P

Gonorrhea? Y N P Condyloma? Y N P

Herpes? Y N P Syphilis? Y N P

Are you sexually active? Y N P Sexual orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you do breast self exams? Y N P Breast lumps? Y N P

Breast pain/tenderness? Y N P Nipple discharge? Y N P

Is there anything else you would like to add or comment on?

**Thank you for your time and effort. Our team looks forward to providing you with the best possible care.**