WHOLE FAMILY
wellness center
LLC

ADULT HEALTH HISTORY

Name _____ Date _____

Address _____

City_____ State _____ Zip code _____

Phone, please circle your preferred number:

(home)_____ (cell) _____ (work) _____

E-mail _____ □ **Yes** □ **No** (if you would like email appointment reminders)

May we email you a monthly newsletter and/or other educational materials? □ **Yes** □ **No**

Age _____ Date of birth _____ Gender □ female □ male

Occupation _____ Hours per week _____ Retired _____ Years _____

Employer _____ Social Security # _____

□ Married □ Partnership □ Single □ Separated □ Divorced □ Widowed

Live with: □ Spouse or partner □ Parents □ Children □ Friends □ Alone

How did you hear about our clinic? If you were referred here, please let us know so that we can thank them.

_____

If internet: □ Google □ Other sites (please specify) _____

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

_____

Next of kin or other to reach in case of emergency: _____

Relationship _____ Phone _____

Address _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the health care provider has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this overview will greatly aid us in helping you reach your health goals.

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 us personally as your physician(s) / health care provider(s)?

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%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

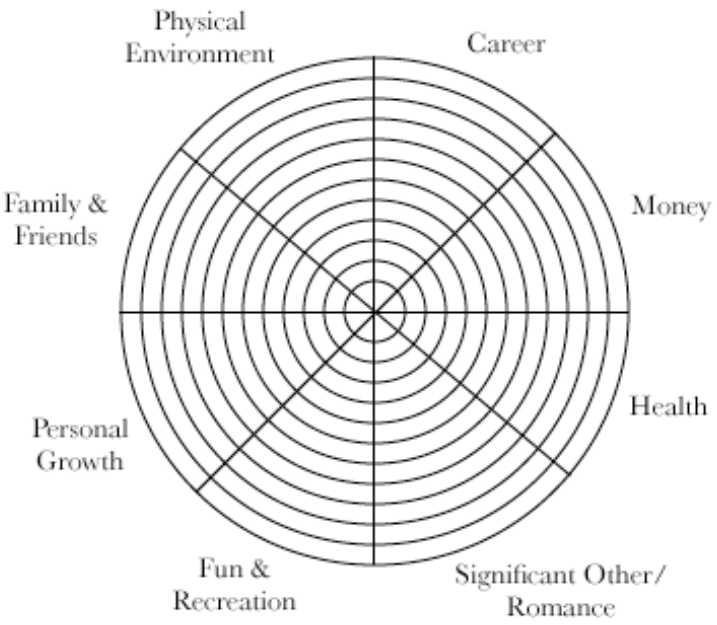
Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

LIFE OF WELLNESS

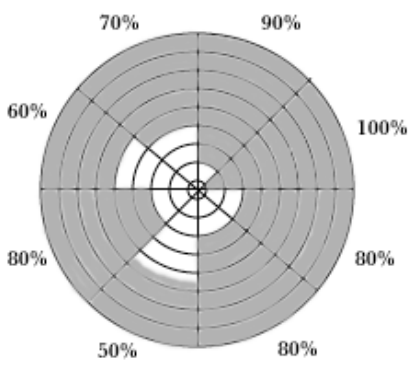
Wellness is a balance of many factors. Using the circle to your right, indicate your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, write in 100% for career.

Do the same for each area of the chart.



Example:



Are you currently receiving health care? 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) _____

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: _____

HOSPITALIZATIONS/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 environmental factors or chemicals? _____

CURRENT MEDICATIONS

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 and/or other supplements you are taking?

1) _____ 7) _____

2) _____ 8) _____

3) _____ 9) _____

4) _____ 10) _____

5) _____ 11) _____

6) _____ 12) _____

GENERAL

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

Maximum Weight: _____ When: _____

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

Main interests and hobbies: _____

Exercise: Y / N If so, what kind? _____ How often / week? _____

Watch TV: Y / N If so, how many hours / week? _____

Read: Y / N If so, how many hours / week? _____

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

TYPICAL FOOD INTAKE IN THE LAST WEEK

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

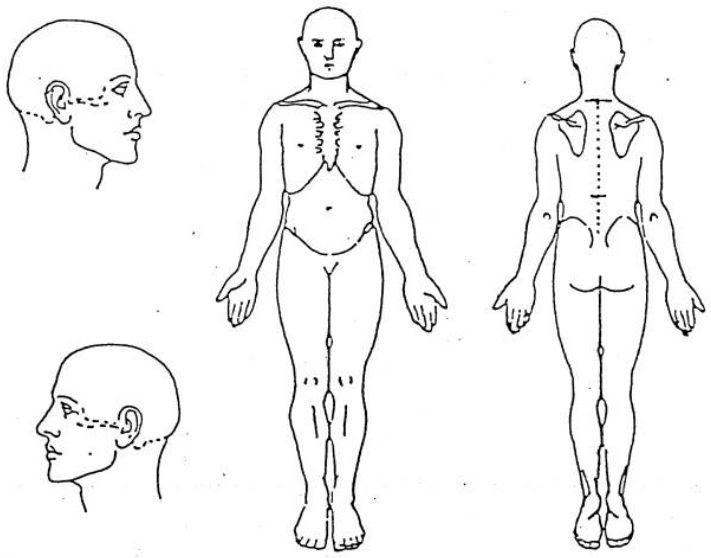
FOR THE FOLLOWING, PLEASE CIRCLE

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

GENERAL

Do you sleep well?	Y N P S
Average 8 hours?	Y N P S
Awake rested?	Y N P S
Have a supportive relationship?	Y N P S
Have a history of abuse?	Y N P S
Experienced a major trauma?	Y N P S
Drink soda?	Y N P S
Use recreational drugs?	Y N P S
Treated for drug dependence?	Y N P S
Drink alcoholic beverages	Y N P S
If so, how many per week? _____	
Treated for alcoholism?	Y N P S
Use tobacco?	Y N P S
If in the past, how many years? _____	
How many packs per day? _____	
Do you enjoy your work?	Y N P S
Take vacations?	Y N P S
Spend time outside?	Y N P S
Eat three meals per day?	Y N P S
Do you go on diets often?	Y N P S
Do you eat out often?	Y N P S
Do you drink coffee?	Y N P S
Drink black/green tea?	Y N P S

Please circle, or shade in the area on the diagram below where you may be experiencing pain.



Please rate each of your current symptoms, from 0 to 3 (3 = worst).

GAN

Irritability / frustration / impatient	0 1 2 3
Depression / high stress	0 1 2 3
Emotional eating	0 1 2 3
Unfulfilled desires	0 1 2 3
Visual problems / floaters	0 1 2 3
Blurred vision / poor night vision	0 1 2 3
Red / dry / itchy eyes	0 1 2 3
Headaches / migraines	0 1 2 3
Dizziness	0 1 2 3
Feeling of lump in throat	0 1 2 3
Muscle twitching / spasms	0 1 2 3
Neck / shoulder tension	0 1 2 3
Jaw clenching / grinding	0 1 2 3
Brittle nails	0 1 2 3
Sighing	0 1 2 3
Sensation or pain under rib cage	0 1 2 3
PMS	0 1 2 3
Genital itching / pain / lesions	0 1 2 3

XIN

Palpitations	0 1 2 3
Chest pain / tightness	0 1 2 3
Insomnia / sleep problems	0 1 2 3
Mood swings	0 1 2 3
Anxiety	0 1 2 3
Restless / easily agitated	0 1 2 3
Vivid dreams	0 1 2 3
Lack of joy in life	0 1 2 3
Forgetful	0 1 2 3
Aversion to heat	0 1 2 3
Bitter taste in mouth	0 1 2 3
Tongue / mouth ulcers / cankers	0 1 2 3

SHEN

Low energy	0 1 2 3
Frequent urination	0 1 2 3
Urinary tract infections	0 1 2 3
Lack of bladder control	0 1 2 3
Wake to urinate	0 1 2 3
Feel cold easily	0 1 2 3
Cold hands / feet	0 1 2 3
Night sweats / hot flushing	0 1 2 3
Low sex drive	0 1 2 3
High sex drive	0 1 2 3
Thyroid imbalance	0 1 2 3
Loss of head hair	0 1 2 3
Hearing problems	0 1 2 3
Crave salty food	0 1 2 3
Fear	0 1 2 3
Poor long term memory	0 1 2 3
Ankle swelling	0 1 2 3
Tinnitus	0 1 2 3

FEI

Dry cough	0 1 2 3
Cough with phlegm	0 1 2 3
Nasal discharge / drip	0 1 2 3
Sinus infection / congestion	0 1 2 3
Itchy / painful throat	0 1 2 3
Dry mouth / throat / nose	0 1 2 3
Skin rashes / hives / eczema	0 1 2 3
Snoring	0 1 2 3
Grief / sadness	0 1 2 3
Shortness of breath	0 1 2 3
Allergies / asthma	0 1 2 3
Weak immune system	0 1 2 3

PI

Heaviness in the head / body	0 1 2 3
Fatigue after eating	0 1 2 3
Difficulty getting up in morning	0 1 2 3
Water retention	0 1 2 3
Muscles tired / weak	0 1 2 3
Bruise easily	0 1 2 3
Unusual bleeding (stool, nose, etc)	0 1 2 3
Bad breath	0 1 2 3
Poor appetite	0 1 2 3
Increased appetite	0 1 2 3
Crave sweets	0 1 2 3
Poor digestion	0 1 2 3
Nausea / vomiting	0 1 2 3
Bloating / gas	0 1 2 3
Hemorrhoids	0 1 2 3
Constipation	0 1 2 3
Loose stool	0 1 2 3
Alternate constipation / loose	0 1 2 3
Intestinal pain / cramping	0 1 2 3
Heartburn	0 1 2 3
Pensive / over-thinking	0 1 2 3

PI (CONT'D)

Overweight	0	1	2	3
Foggy mind	0	1	2	3
Yeast infections	0	1	2	3
Aversion to cold	0	1	2	3
Cold nose	0	1	2	3
Increased thirst	0	1	2	3
Prefer warm / cold drinks	0	1	2	3
Sweats easily	0	1	2	3

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

FEMALE REPRODUCTIVE

Age of first menses: _____
Age of last menses (if menopausal): _____
Length of cycle: _____ days
Duration of menses (flow): _____ days

Are your cycles regular?	Y	N	P	S
Painful menses?	Y	N	P	S
Heavy or excessive flow?	Y	N	P	S
PMS?	Y	N	P	S

Symptoms: _____
_____

Bleeding between cycles?	Y	N	P	S
Clotting?	Y	N	P	S
Endometriosis?	Y	N	P	S
Ovarian cysts?	Y	N	P	S
Vaginal odor?	Y	N	P	S
Vaginal discharge?	Y	N	P	S
Date of last PAP smear?	Y	N	P	S
Abnormal PAP?	Y	N	P	S
Cervical dysplasia?	Y	N	P	S
Are you sexually active?	Y	N	P	S

Sexual orientation: _____
Birth control? Type: _____
Current/past birth control, how long? _____

Pain during intercourse?	Y	N	P	S
Sexually transmitted infections?	Y	N	P	S
Difficulty conceiving?	Y	N	P	S

Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____

Do you do self breast exams?	Y	N	P	S
Breast pain/tenderness?	Y	N	P	S
Breast lumps?	Y	N	P	S
Nipple discharge?	Y	N	P	S
Menopausal symptoms?	Y	N	P	S

MALE REPRODUCTIVE

Are you sexually active?	Y	N	P	S

Sexual orientation: _____
Birth control? Type: _____

Discharge or sores?	Y	N	P	S
Sexually transmitted infections?	Y	N	P	S
Hernias?	Y	N	P	S
Testicular masses?	Y	N	P	S
Testicular pain?	Y	N	P	S
Prostate disease?	Y	N	P	S
Impotence?	Y	N	P	S
Premature ejaculation?	Y	N	P	S