WHOLE FAMILY
wellness center
LLC

ADULT HEALTH HISTORY

Name _____ Date _____

Address _____

City_____ State _____ Zip code _____

Phone, please circle your preferred number for us to contact you

(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 physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your responses to the following questions will help us understand your needs and how to help you reach your health goals. Your time, thoughtfulness and honesty in completing this overview will greatly aid us to assist your health needs.

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) / healthcare 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?

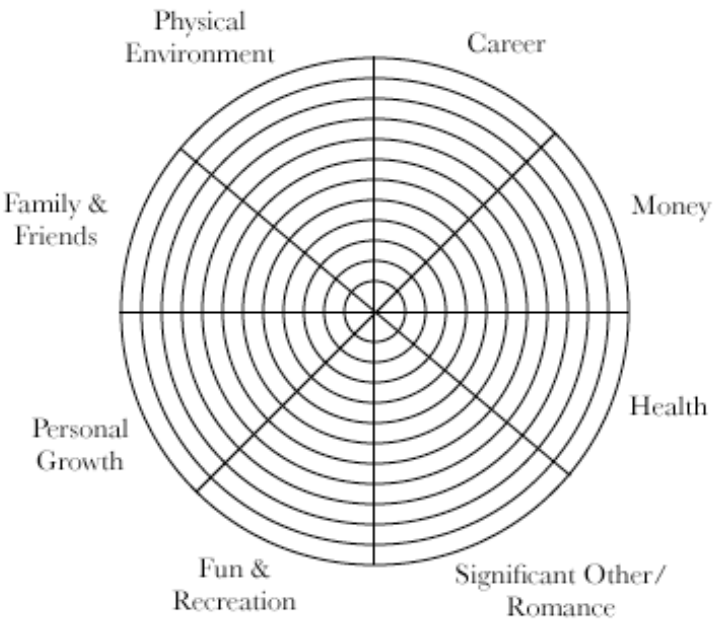
Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

LIFE OF WELLNESS

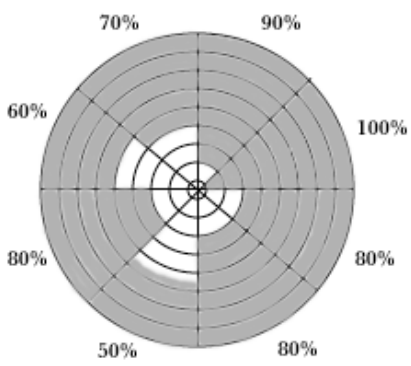
Wellness is a balance of many factors. Using the circle to your right, indicate your level of satisfaction in each area as it relates to you.

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 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) _____
8) _____
9) _____
10) _____

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: _____

CHILDHOOD ILLNESSES

Birth country/city & state: _____ Birth time (if known): _____ Birth weight: _____

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

Scarlet fever	Diphtheria	Rheumatic fever
Mumps	Measles	German measles

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 environmentals 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

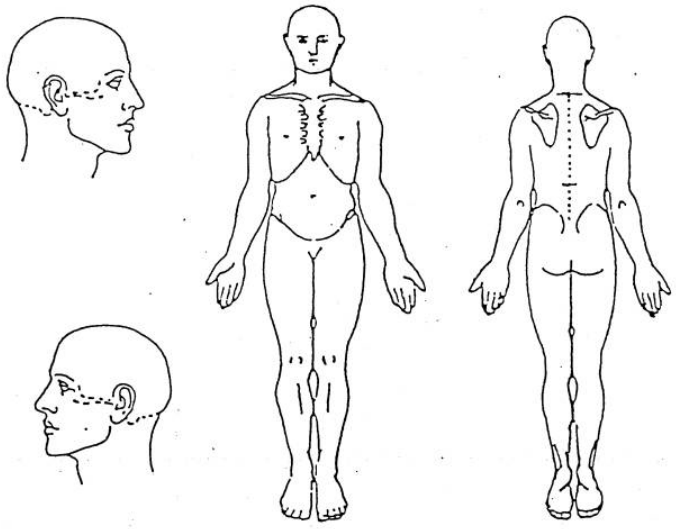
GENERAL

Do you sleep well?	Y N P S
Average 6-8 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

GENERAL CONT'D.

Do you eat refined sugar?	Y N P S
Do you add salt to your food?	Y N P S

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



Metabolic Assessment

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI (continued)				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?		Yes	No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category XI

Cannot stay asleep	**0**	**1**	**2**	**3**
Crave salt	**0**	**1**	**2**	**3**
Slow starter in the morning	**0**	**1**	**2**	**3**
Afternoon fatigue	**0**	**1**	**2**	**3**
Dizziness when standing up quickly	**0**	**1**	**2**	**3**
Afternoon headaches	**0**	**1**	**2**	**3**
Headaches with exertion or stress	**0**	**1**	**2**	**3**
Weak nails	**0**	**1**	**2**	**3**

Category XII

Cannot fall asleep	**0**	**1**	**2**	**3**
Perspire easily	**0**	**1**	**2**	**3**
Under high amount of stress	**0**	**1**	**2**	**3**
Weight gain when under stress	**0**	**1**	**2**	**3**
Wake up tired even after 6 or more hours of sleep	**0**	**1**	**2**	**3**
Excessive perspiration or perspiration with little or no activity	**0**	**1**	**2**	**3**

Category XIII

Edema and swelling in ankles and wrists	**0**	**1**	**2**	**3**
Muscle cramping	**0**	**1**	**2**	**3**
Poor muscle endurance	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Frequent thirst	**0**	**1**	**2**	**3**
Crave salt	**0**	**1**	**2**	**3**
Abnormal sweating from minimal activity	**0**	**1**	**2**	**3**
Alteration in bowel regularity	**0**	**1**	**2**	**3**
Inability to hold breath for long periods	**0**	**1**	**2**	**3**
Shallow, rapid breathing	**0**	**1**	**2**	**3**

Category XIV

Tired/sluggish	**0**	**1**	**2**	**3**
Feel cold—hands, feet, all over	**0**	**1**	**2**	**3**
Require excessive amounts of sleep to function properly	**0**	**1**	**2**	**3**
Increase in weight even with low-calorie diet	**0**	**1**	**2**	**3**
Gain weight easily	**0**	**1**	**2**	**3**
Difficult, infrequent bowel movements	**0**	**1**	**2**	**3**
Depression/lack of motivation	**0**	**1**	**2**	**3**
Morning headaches that wear off as the day progresses	**0**	**1**	**2**	**3**
Outer third of eyebrow thins	**0**	**1**	**2**	**3**
Thinning of hair on scalp, face, or genitals, or excessive hair loss	**0**	**1**	**2**	**3**
Dryness of skin and/or scalp	**0**	**1**	**2**	**3**
Mental sluggishness	**0**	**1**	**2**	**3**

Category XV

Heart palpitations	**0**	**1**	**2**	**3**
Inward trembling	**0**	**1**	**2**	**3**
Increased pulse even at rest	**0**	**1**	**2**	**3**
Nervous and emotional	**0**	**1**	**2**	**3**
Insomnia	**0**	**1**	**2**	**3**
Night sweats	**0**	**1**	**2**	**3**
Difficulty gaining weight	**0**	**1**	**2**	**3**

Category XVI

Diminished sex drive	**0**	**1**	**2**	**3**
Menstrual disorders or lack of menstruation	**0**	**1**	**2**	**3**
Increased ability to eat sugars without symptoms	**0**	**1**	**2**	**3**

Category XVII

Increased sex drive	**0**	**1**	**2**	**3**
Tolerance to sugars reduced	**0**	**1**	**2**	**3**
"Splitting" - type headaches	**0**	**1**	**2**	**3**

Category XVIII *(Males Only)*

Urination difficulty or dribbling	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Pain inside of legs or heels	**0**	**1**	**2**	**3**
Feeling of incomplete bowel emptying	**0**	**1**	**2**	**3**
Leg twitching at night	**0**	**1**	**2**	**3**

Category XIX *(Males Only)*

Decreased libido	**0**	**1**	**2**	**3**
Decreased number of spontaneous morning erections	**0**	**1**	**2**	**3**
Decreased fullness of erections	**0**	**1**	**2**	**3**
Difficulty maintaining morning erections	**0**	**1**	**2**	**3**
Spells of mental fatigue	**0**	**1**	**2**	**3**
Inability to concentrate	**0**	**1**	**2**	**3**
Episodes of depression	**0**	**1**	**2**	**3**
Muscle soreness	**0**	**1**	**2**	**3**
Decreased physical stamina	**0**	**1**	**2**	**3**
Unexplained weight gain	**0**	**1**	**2**	**3**
Increase in fat distribution around chest and hips	**0**	**1**	**2**	**3**
Sweating attacks	**0**	**1**	**2**	**3**
More emotional than in the past	**0**	**1**	**2**	**3**

Category XX *(Menstruating Females Only)*

Perimenopausal	**Yes**	**No**		
Alternating menstrual cycle lengths	**Yes**	**No**		
Extended menstrual cycle (greater than 32 days)	**Yes**	**No**		
Shortened menstrual cycle (less than 24 days)	**Yes**	**No**		
Pain and cramping during periods	**0**	**1**	**2**	**3**
Scanty blood flow	**0**	**1**	**2**	**3**
Heavy blood flow	**0**	**1**	**2**	**3**
Breast pain and swelling during menses	**0**	**1**	**2**	**3**
Pelvic pain during menses	**0**	**1**	**2**	**3**
Irritable and depressed during menses	**0**	**1**	**2**	**3**
Acne	**0**	**1**	**2**	**3**
Facial hair growth	**0**	**1**	**2**	**3**
Hair loss/thinning	**0**	**1**	**2**	**3**

Category XXI *(Menopausal Females Only)*

How many years have you been menopausal?	**_____ years**			
Since menopause, do you ever have uterine bleeding?	**Yes**	**No**		
Hot flashes	**0**	**1**	**2**	**3**
Mental fogginess	**0**	**1**	**2**	**3**
Disinterest in sex	**0**	**1**	**2**	**3**
Mood swings	**0**	**1**	**2**	**3**
Depression	**0**	**1**	**2**	**3**
Painful intercourse	**0**	**1**	**2**	**3**
Shrinking breasts	**0**	**1**	**2**	**3**
Facial hair growth	**0**	**1**	**2**	**3**
Acne	**0**	**1**	**2**	**3**
Increased vaginal pain, dryness, or itching	**0**	**1**	**2**	**3**