Thank you in advance

for taking the time to fill out this form in its entirety. It is a crucial part for our team to learn about you so that we can join you on your journey to optimal health.

PATIENT INFORMATION

Name: _____ DOB: _____

Preferred Name: _____

Marital Status

◯ Married ◯ Divorced ◯ Legally Separated ◯ Significant Other ◯ Single ◯ Widowed ◯ Decline

Background

Birthplace: _____

◯ American Indian or Alaska Native ◯ Native Hawaiian or other Pacific Islander ◯ White ◯ Black or African American ◯ Asian ◯ Decline

◯ Hispanic ◯ Other _____

PHARMACY

Local: _____ Address: _____ Phone: _____ ◯ Preferred
OR CROSS STREETS

Alternative: _____ Address: _____ Phone: _____ ◯ Preferred
OR CROSS STREETS

CARE TEAM (Include coach and/or therapist if pertinent)

Specialist: _____ Specialty: _____ Phone: _____

Specialist: _____ Specialty: _____ Phone: _____

Specialist: _____ Specialty: _____ Phone: _____

Specialist: _____ Specialty: _____ Phone: _____

Specialist: _____ Specialty: _____ Phone: _____

Specialist: _____ Specialty: _____ Phone: _____

WHAT ARE YOUR SHORT- AND LONG-TERM HEALTH AND WELLNESS GOALS?

Short: _____

_____

Long: _____

_____

PERSONAL MEDICAL HISTORY

Please check all that apply and note date of onset.

DENTAL HISTORY

Do you visit the dentist two times per year for regular check ups? ○ Yes ○ No

GASTROINTESTINAL

Irritable Bowel Syndrome	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Inflammatory Bowel Disease	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Crohn's Disease	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Ulcerative Colitis	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Diverticulosis	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Gastric Ulcer	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Peptic Ulcer Disease	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Acid Reflux (Gerd)	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Celiac Disease	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Gallstones	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

CARDIOVASCULAR

Coronary Artery Disease	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Heart Attack	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Stroke	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Elevated Cholesterol	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Angina	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Hypertension	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Rheumatic Fever	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Mitral Valve Prolapse	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Atrial Fibrillation	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

MUSCULOSKELETAL / PAIN

Osteoarthritis	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Fibromyalgia	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Osteoporosis	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Osteopenia	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Sciatica	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

METABOLIC / ENDOCRINE

Diabetes, Type 1	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Diabetes, Type 2	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Hyperglycemia	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Metabolic Syndrome	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Hypothyroidism	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Hyperthyroidism	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Hashimoto's Thyroiditis	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Polycystic Ovary Syndrome (PCOS)	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Infertility	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Bulimia	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Anorexia	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Eating Disorder (non-specific)	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

CANCER

Lung Cancer	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Breast Cancer	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Colon Cancer	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Ovarian Cancer	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Prostate Cancer	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Skin Cancer	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Other Cancer	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

GENITAL AND URINARY SYSTEMS

Renal Failure	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Kidney Stones	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Gout	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Interstitial Cystitis	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Frequent Urinary Tract Infection	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Erectile Dysfunction	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

INFLAMMATORY / AUTOIMMUNE

Autoimmune Disorder	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Rheumatoid Arthritis	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Lupus	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Food Allergies	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Environmental Allergies	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

PERSONAL MEDICAL HISTORY (continued)

BLOOD DISORDERS

Anemia	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Bleeding Disorder	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
History of Blood Transfusion	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Human Immunodeficiency Virus (HIV), positive	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

RESPIRATORY

Asthma	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Chronic Sinusitis	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Bronchitis	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Emphysema	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Sleep Apnea	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

NEUROLOGIC / MOOD

Depression	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Anxiety	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Bipolar Disorder	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Schizophrenia	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Migraine Headaches	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Attention Deficit Hyperactivity Disorder	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Autism	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Vertigo	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Memory Loss	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Parkinson's Disease	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Multiple Sclerosis	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Seizures	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

DERMATOLOGY

Psoriasis	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Eczema	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
Herpes	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

Other Skin Issues:

_____	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
_____	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
_____	○ Past Issue	○ Ongoing Issue	Date of Onset: _____
_____	○ Past Issue	○ Ongoing Issue	Date of Onset: _____

PREVENTATIVE TESTS

Note the date you last had the following preventative tests, if applicable, and if there were any abnormal results.

Full Physical Exam	Date: _____	Abnormal? ◯ Yes ◯ No
Bone Density	Date: _____	Abnormal? ◯ Yes ◯ No
Colonoscopy	Date: _____	Abnormal? ◯ Yes ◯ No
Cardiac Stress Test	Date: _____	Abnormal? ◯ Yes ◯ No
EKG	Date: _____	Abnormal? ◯ Yes ◯ No
Hemoccult (stool test for blood)	Date: _____	Abnormal? ◯ Yes ◯ No
Pap Smear	Date: _____	Abnormal? ◯ Yes ◯ No
PSA	Date: _____	Abnormal? ◯ Yes ◯ No

IMMUNIZATION

Have you received immunizations for the following?

Shingles Vaccine	◯ Yes ◯ No
Pneumonia Vaccine	◯ Yes ◯ No
Meningitis Vaccine	◯ Yes ◯ No
TDAP (tetanus / diphtheria / pertussis)	◯ Yes ◯ No
Covid-19 Vaccine	◯ Yes ◯ No

Other Vaccine(s):

WEIGHT

Current Weight: _____

Weight change in the last year? ◯ Yes ◯ No Amount: _____

Lowest adult weight: _____ Age: _____

Highest adult weight: _____ Age: _____

What do you believe influences your weight fluctuations?

FEMALE PATIENTS

Abnormal Pap Smear: ◯ Yes ◯ No

Age of first menstrual period: _____ Date of last menstrual period: _____ Age of menopause: _____

Last mammogram: _____ Form of contraception (if any): _____

Have you ever experienced

◯ Endometriosis ◯ Fibroids ◯ Infertility ◯ Painful periods

Pregnancy

Currently Pregnant? ◯ Yes ◯ No Currently breastfeeding? ◯ Yes ◯ No Planning pregnancy? ◯ Yes ◯ No

Number of Pregnancies : _____

Number of Deliveries : _____

Number of Miscarriages : _____

SURGERY / HOSPITALIZATIONS / INJURY HISTORY

Please list surgeries/procedures and add notes as needed.

Year	Surgery / Hospitalization / Injury	Hospital / Location	Complications / Additional Comments

Have you ever had a bad reaction to anesthesia? ◯ Yes ◯ No

FAMILY HISTORY

Write the approximate age of onset in the box for the appropriate disease and family member.

	Mother	Father	Sister	Brother	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other Relative
ADHD										
Alcoholism / Substance Abuse										
Arrhythmia										
Asthma										
Autoimmune Disease										
Blood Clots										
Cancer										
Celiac Disease										
Dementia										
Diabetes										
Heart Disease / Attack										
High Blood Pressure										
High Cholesterol										
Inflammatory Bowel Disease										
Kidney Disease										
Lung Disease										
Liver Disease										
Mental Health Issues										
Obesity										
Stroke										
Sudden Death										
Thyroid Conditions										
Other										

MEDICATIONS / SUPPLEMENTS / PERFORMANCE ENHANCEMENT PRODUCTS

Please list any medications or supplements that you are taking, including over-the-counter meds.

◯ Taking none

Name	Dose	How often you take it	Reason for taking

Have you had prolonged use of NSAIDs (Aspirin, Ibuprofen, Naproxen), Tylenol, opioids, acid blockers? ◯ Yes ◯ No

Please list:

_____

_____

_____

_____

_____

_____

Have you taken antibiotics frequently? ◯ Yes ◯ No

Greater than 3 times a year? ◯ Yes ◯ No

Please list:

_____

_____

Do you currently use oral contraceptives or any other form of hormone replacement? ◯ Yes ◯ No

Please list:

_____

_____

Are you currently on oral steroids or receiving steroid injections on a regular basis? ◯ Yes ◯ No

Please list:

_____

_____

MEDICATION ALLERGIES

Please list any known allergies. ◯ None

Medication	Reaction

Other allergies (i.e., latex, environmental): _____

LIFESTYLE HISTORY

Education Background: ◯ GED ◯ High School ◯ College ◯ Advanced Degree ◯ Technical/Trade

With whom do you live? _____

Occupation: _____

Leisure activities: _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Do you have any pets? _____

SOCIAL HISTORY

Tobacco

◯ None Currently smoking ◯ Yes ◯ No How many years? _____

Packs per day: _____ Secondhand smoke exposure? ◯ Yes ◯ No

Drugs

◯ None ◯ Past Use ◯ Current Type: ◯ Marijuana ◯ Amphetamines ◯ Cocaine ◯ Other

Alcohol (1 drink = 5 oz wine, 12 oz beer, or 1.5 oz spirits)

How many drinks per week, currently? ◯ None ◯ 1–3 ◯ 4–6 ◯ 7–10 ◯ More than 10

Previous alcohol intake? ◯ Yes ◯ No

Have you ever been told to cut down on your alcohol intake? ◯ Yes ◯ No

Have you ever thought about getting help to control or stop your drinking? ◯ Yes ◯ No

Personal Safety

I feel safe at home: ◯ Yes ◯ No

Is there anyone you are afraid of? ◯ Yes ◯ No

Do you have a history of abuse? ◯ Yes ◯ No

PREVENTATIVE HEALTH

Regular use of sunscreen: ◯ Yes ◯ No

Regular use of seat belts: ◯ Yes ◯ No

Helmet use when appropriate: ◯ Yes ◯ No

NUTRITION INFORMATION

List any known food allergies, sensitivities or intolerances: _____

What are your symptoms after consumption? _____

Do you follow a particular diet? If so, check all that apply:

◯ Vegetarian ◯ Vegan ◯ Paleo ◯ Gluten-Free ◯ Low-Carb ◯ Other: _____

Where do you obtain nutrition information?

◯ Family ◯ Friend ◯ Nutritionist ◯ Media ◯ Other:

_____

How many cups (8 oz) of water do you drink during the day? ◯ 8–10 ◯ 6–8 ◯ 4–6 ◯ 2–4 ◯ <2

How many cups of caffeine (coffee, tea, energy drinks) do you consume during the day? _____

How many meals do you eat away from home per week? _____

Do you eat fish or seafood 2x or more per week? What kind(s): _____

Usual Intake (Please be as detailed as possible.)

Day	Time	Food
Wake Up		
Breakfast		
Lunch		
Snack(s)		
Dinner		
Bedtime		

EXERCISE INFORMATION

Are you currently following an exercise routine? ◯ Yes ◯ No

If no, when was the last time you followed a regular exercise routine? _____

WEEKLY EXERCISE ROUTINE

	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Strength Training							
Cardio							
Restorative Yoga, Stretching							
Sports							
Other: _____							

Type of exercise you enjoy: _____

Type of exercise you dislike: _____

Do you use or have you used a heart rate monitor while exercising? ◯ Yes ◯ No

STRESS AND SLEEP

Do you believe you have excessive stress in your life? ◯ Yes ◯ No

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

What are your major stressors? Rate those below on a scale of 1 to 10 (10 being high)
Family_____ Social _____ Money _____ Health _____ Work _____ Other _____

How do you manage your stress? _____

Do you currently practice meditation or relaxation techniques? ◯ Yes ◯ No

Have you ever been abused or a victim of a crime, or experienced significant trauma? ◯ Yes ◯ No

Have you ever sought counseling? ◯ Yes ◯ No

Are you currently in therapy? ◯ Yes ◯ No If yes, describe: _____

_____

Typical number of hours of sleep per night: ◯ <6 ◯ 7–8 ◯ >9

Do you have trouble falling asleep? ◯ Yes ◯ No

Do you wake up multiple times during the night? ◯ Yes ◯ No

Do you snore? ◯ Yes ◯ No

Do you feel rested upon waking? ◯ Yes ◯ No

Do you feel that you need a nap during the day? ◯ Yes ◯ No

Do you use sleeping aids? ◯ Yes ◯ No If yes, explain: _____

READINESS TO CHANGE

On a scale of 5 (very willing) to 1 (not willing), how ready are you to implement changes in the following areas in order to improve your health and wellness?

Significantly modify your diet	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5
Take nutritional supplements daily	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5
Keep a nutrition and lifestyle journal each day	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5
Modify your lifestyle (sleep habits, work demands)	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5
Practice a relaxation technique (meditation, deep breathing, etc.)	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5
Engage in a regular exercise program	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5
Have periodic lab tests to assess your progress	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5
How supportive do you feel the people in your household will be to implementing the above changes?	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5
How much ongoing support and contact from our professional staff would be helpful to you as you implement the above changes?	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5
Medical provider	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5
Registered dietitian	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5
Personal trainer	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

MEDICAL SYMPTOMS QUESTIONAIRE

Based on the past 14 days, rate each of the following symptoms based upon your typical health profile.

Please use the scale shown below to describe the severity of your symptom.

0	1	2	3	4
Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe

Head

____ Headaches
____ Dizziness/faintness
____ Insomnia

Eyes

____ Watery eyes
____ Itchy eyes
____ Swollen, reddened or sticky eyelids
____ Vision problems (excluding near- or farsighted)

Ears

____ Ear infections
____ Popping of ears
____ Ringing in ears
____ Itchy ears

Nose

____ Stuffy nose
____ Sinus problems
____ Frequent sneezing attacks
____ Nose bleeding

Mouth

____ Need to clear throat
____ Choking on food
____ Sore throat
____ Canker sores

Skin

____ Acne
____ Rashes
____ Hair loss
____ Excessive hair growth
____ Excessive sweating
____ Flushing

Heart

____ Irregular or skipped heartbeat
____ Rapid or pounding heartbeat
____ Chest pain

Lungs

____ Chest congestion
____ Asthma
____ Bronchitis
____ Difficulty breathing
____ Frequent coughing

Digestive Tract

____ Nausea, vomiting
____ Diarrhea, loose stools
____ Constipation (hard / infrequent stools / or straining)
____ Bloated feeling
____ Burping
____ Passing gas
____ Heartburn / acid taste in mouth
____ Stomach or abdominal pain

Urology

____ Frequent urination
____ Painful urination
____ Genital discharge

Joints / Muscles

____ Pain or aches in joints / arthritis
____ Warm, swollen joints
____ Stiffness or limitation of movement
____ Pain or aches in muscles
____ Muscle weakness

Weight

____ Excessive eating
____ Food cravings
____ Overweight
____ Difficulty losing weight
____ Water retention
____ Difficulty gaining weight

Energy / Activity

____ Excessive fatigue
____ Hyperactivity
____ Restlessness

Mind

____ Poor memory
____ Poor concentration
____ Poor physical coordination
____ Difficulty making decisions
____ Speech difficulty
____ Learning disabilities

Emotions

____ Mood swings
____ Anxiety
____ Anger, irritability, aggressiveness
____ Depression / sadness
____ Obsessive, compulsive behaviors