Date: ______________
Name: ____
Address: ____
City: ____State: ______ Zip: ________
Preferred Phone: ____
Cell Phone: ____
Okay to text? Y/N
Email: ____

Wellness Intake Form

If you could magically eliminate 5 health or wellness concerns what could they be?

1.____
Comments: ____
____

2.____
Comments: ____
____

3. ____
Comments: ____
____

4. ____
Comments: ____
____

5.____
Comments: ____
____

Adult Health Questionnaire

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with our specialist. Please fill out this questionnaire. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank.

Patient Name: ____

Patient Date of Birth: _______________ Today's Date: ____________________________

what would you like to talk about on your first visit: _________________________________

____

____

____

Medical History

Please list any medication allergies or reactions:

____

____

____

Please check to indicate if you ever had the following conditions:

___Diabetes
___High Blood Pressure
___Asthma
___Heart attack
___Kidney Disease
___Hepatitis
___Thyroid Disease
___Seizures
___Stroke
___Depression
___Emphysema
___Tuberculosis
___Congestive Heart Failure
___Coronary Artery Disease
___Eye problems
___Arrhythmia
___Cancer (Type):_________________________________
___ Sexual Transmitted Disease (Type):_________________________________
___ Other, Please explain: _________________________________

____

____

____

Please list any surgeries or hospital stays you have had and their approximate date / year.

Type of surgery / reason for hospitalization	Date

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

When was your last physical?

Please list ALL medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please list your SUPPLEMENTS and VITAMINS first.

Medication Name (List Supplements first)	*Dosage*

What pharmacy do you use for prescription medications?

____________________________________ PH: ________________________

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider's Name	*Condition they are treating you for*
______________________________	____
______________________________	____
______________________________	____
______________________________	____
______________________________	____

Please note dates of you most recent immunizations:

	Approximate Date
Tetanus	____________________________
Pneumonia	____________________________
Influenza	____________________________
Hepatitis B	____________________________
Other: _______________________	____________________________
Other: _______________________	____________________________

If you have had any of the following tests done, please note when the test or tests were done and what the results were, if known:

Test	*Approximate Date*	*Results*
Cholesterol	__________________	_________________
Pap smear/pelvic	__________________	_________________
Mammogram	__________________	_________________
Blood in stool	__________________	_________________

Personal History

Are you currently married or living with a significant other? ___Yes ___No

Who lives with you at home? ____

Are you employed? ___Yes ___No

If yes, what kind of work do you do? ____

If no, what kind of work do you do? ____

If no, is this by choice? __________ Disability? ____

Other? ____

Do you exercise more than 3 times per week? ___Yes ___No

Do you often feel there is something seriously wrong
with your body? ___Yes ___No

Are you having money problems which limit your access
To food, shelter or medical care? ___Yes ___No

In the last year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation? ___Yes ___No

Do you have some form of church or spiritual support? ___Yes ___No

Family History

Check any of the diseases that run in your family AND please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Child	Other (please explain)
Alcoholism or Drug Use											
Cancer											
Cancer Type											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

Family History

Other Comments:

____

____

____

Health Habits

Do you smoke or use any tobacco products? ___Quit ___Yes ___No

Number of cigarettes each day? ______

For how many years? ______

Other forms of tobacco used?____

Do you drink alcohol? ___Quit ___Yes ___No

How much? _____________

How often? ______________

Have you ever felt that you should cut down on your drinking? ___Yes ___No

Have you regularly used other drugs? ___Yes ___No

If yes, are you still using them? ___Yes ___No

Sexual History

Are you sexually active? ___Yes ___No

With: ___Men ___Women. ___Both

Do you feel you are at risk for HIV/ AIDS? ___Yes ___No

Do you have children? ___Yes ___No

How many children do you have? _________

Do you use any form of birth control? ___Yes ___No

If yes, which type/ brand? ____

Women Only

Have you ever been pregnant? ___Yes ___No

How many times? _________

How many miscarriages? _________

How many children do you have living? _____________

Do you have menstrual periods? ___Yes ___No

If no, at what age did they stop? __________

If yes, are your periods regular? ____

Sleep

Do you sleep well? ___Yes ___No

About how many hours do you sleep? __________________

Do you wake up with pains or stiffness? ___Yes ___No

Do you wear a CPAP device? ___Yes ___No

Do you sleep on your back? ___Yes ___No

Do you sleep on your side? ___Yes ___No

Do you have dreams every night? ___Yes ___No

If yes, what do you dream about? ____

____

Are you a stomach sleeper? ___Yes ___No

What kind of pillow do you use?

Please describe your pillow size, firmness, softness, etc.

____

____

Describe your mattress. Does it dip or sag and does it offer proper support? _________________

____

Have you ever had your posture checked? ___Yes ___No

If yes, when and what were your results? ____

____

What type of shoes do you typically wear everyday?

____

Other Comments:

____

____

____

____

Thank you,

Please indicate with an X the places you have pain.

Front **Back**