Senara Medical Weight Loss & Anti-Aging Center: New Patient History

GENERAL INFORMATION

TODAY'S DATE ____________ HOW DID YOU HEAR ABOUT US? ____________

FIRST NAME ____________ LAST NAME ____________

DATE OF BIRTH ____________ AGE ____________ GENDER: ☐ M ☐ F

ADDRESS ____________

CITY ____________ STATE ____________ ZIPCODE ____________

PHONE (HOME) ____________ (CELL) ____________ (WORK) ____________

E-MAIL ____________

OCCUPATION ____________ MARITAL STATUS ☐ M ☐ S ☐ D ☐ W ☐ Other

GENETIC BACKROUND *(CHECK ALL THAT APPLY)* ☐ AFRICAN AMERICAN ☐ HISPANIC ☐ MEDITERRANEAN ☐ ASIAN ☐ NATIVE AMERICAN ☐ CAUCASIAN ☐ NORTHERN EUROPEAN ☐ OTHER

EMERGENCY CONTACT NAME ____________ RELATIONSHIP ____________

EMERGENCY CONTACT PHONE ____________

REASON FOR VISIT

WHAT ARE YOUR HEALTH OR WEIGHT LOSS GOALS?

1. ____________
2. ____________
3. ____________

WHAT ARE YOUR BIGGEST OBSTACLES TO ACHIEVING THOSE GOALS?

1. ____________
2. ____________
3. ____________

CURRENT HEALTH AND WELLNESS CARE PROFESSIONALS

Are you currently seeing a physician for any reason. If yes, explain reason: ☐ Yes ☐ No

____

When, where and from whom did you last receive medical or health care?

____

MEDICAL CARE TEAM	NAME	CITY, STATE	PHONE
Primary Care Physician	______	______	______
Optometrist/Opthalmologist	______	______	______
Chiropractor	______	______	______
Other: ______	______	______	______
Specialist 1: ______	______	______	______
Specialist 2: ______	______	______	______
Specialist 3: ______	______	______	______

CURRENT HEALTH CONCERNS

Please tell us about your current health concerns and medical conditions. Examples would include: acid reflux, diabetes, bloating, weight gain, etc.

(1) PROBLEM/DIAGNOSIS

Health Concern (specify):		
When did the problem begin?		Severity of the problem? ☐ Mild ☐ Moderate ☐ Severe
What symptoms do you experience?		
What makes it better?		
What makes it worse?		
What medications or supplements are you taking for this condition?		
Medication/Supplement	Dosage	Frequency
Please describe the progression of the problem, including prior treatments and approaches to addressing it.		

(2) PROBLEM/DIAGNOSIS

Health Concern (specify):		
When did the problem begin?		Severity of the problem? ◻ Mild ◻ Moderate ◻ Severe
What symptoms do you experience?		
What makes it better?		
What makes it worse?		
What medications or supplements are you taking for this condition?		
Medication/Supplement	Dosage	Frequency
Please describe the progression of the problem, including prior treatments and approaches to addressing it.		

(3) PROBLEM/DIAGNOSIS

Health Concern (specify):		
When did the problem begin?		Severity of the problem? ◻ Mild ◻ Moderate ◻ Severe
What symptoms do you experience?		
What makes it better?		
What makes it worse?		
What medications or supplements are you taking for this condition?		
Medication/Supplement	Dosage	Frequency
Please describe the progression of the problem, including prior treatments and approaches to addressing it.		

MEDICAL HISTORY

Illnesses/Conditions: ***Check appropriate Box: YES****-a condition you currently have,* ***PAST****-a condition you've had in the past*

Gastrointestinal	
Irritable Bowel Syndrome	□ Yes □ Past
GERD (reflux)	□ Yes □ Past
Crohn's Disease/Ulcerative Colitis	□ Yes □ Past
Peptic Ulcer Disease	□ Yes □ Past
Celiac Disease	□ Yes □ Past
Gallstones	□ Yes □ Past
Other:	□ Yes □ Past
Respiratory	
Bronchitis	□ Yes □ Past
Asthma	□ Yes □ Past
Emphysema	□ Yes □ Past
Pneumonia	□ Yes □ Past
Sinusitis	□ Yes □ Past
Sleep Apnea	□ Yes □ Past
Other:	□ Yes □ Past
Urinary/Genital	
Kidney Stones	□ Yes □ Past
Gout	□ Yes □ Past
Interstitial Cystitis	□ Yes □ Past
Frequent Yeast Infections	□ Yes □ Past
Frequent Urinary Tract Infections	□ Yes □ Past
Sexual Dysfunction	□ Yes □ Past
Sexually Transmitted Diseases	□ Yes □ Past
Other:	□ Yes □ Past
Endocrine/Metabolic	
Diabetes	□ Yes □ Past
Hypothyroidism (low thyroid)	□ Yes □ Past
Hyperthyroidism (overactive thyroid)	□ Yes □ Past
Polycystic Ovarian Syndrome	□ Yes □ Past
Infertility	□ Yes □ Past
Metabolic Syndrome/Insulin Resistance	□ Yes □ Past
Eating Disorder	□ Yes □ Past
Hypoglycemia	□ Yes □ Past
Other:	□ Yes □ Past
Inflammatory/Immune	
Rheumatoid Arthritis	□ Yes □ Past
Chronic Fatigue Syndrome	□ Yes □ Past
Food Allergies	□ Yes □ Past
Environmental Allergies	□ Yes □ Past
Multiple Chemical Sensitivities	□ Yes □ Past
Autoimmune Disease	□ Yes □ Past
Immune Deficiency	□ Yes □ Past
Mononucleosis	□ Yes □ Past

Hepatitis	□ Yes □ Past
Other:	□ Yes □ Past
Musculoskeletal	
Fibromyalgia	□ Yes □ Past
Osteoarthritis	□ Yes □ Past
Chronic Pain	□ Yes □ Past
Other:	□ Yes □ Past
Skin	
Eczema	□ Yes □ Past
Psoriasis	□ Yes □ Past
Acne	□ Yes □ Past
Skin Cancer	□ Yes □ Past
Other:	□ Yes □ Past
Cardiovascular	
Angina	□ Yes □ Past
Heart Attack	□ Yes □ Past
Heart Failure	□ Yes □ Past
Hypertension (high blood pressure)	□ Yes □ Past
Stroke	□ Yes □ Past
High Blood Fats (cholesterol, triglycerides)	□ Yes □ Past
Rheumatic Fever	□ Yes □ Past
Arrythmia (irregular heart rate)	□ Yes □ Past
Murmur	□ Yes □ Past
Mitral Valve Prolapse	□ Yes □ Past
Other:	□ Yes □ Past
Neurologic/Emotional	
Epilepsy/Seizures	□ Yes □ Past
ADD/ADHD	□ Yes □ Past
Headaches	□ Yes □ Past
Migraines	□ Yes □ Past
Depression	□ Yes □ Past
Anxiety	□ Yes □ Past
Autism	□ Yes □ Past
Multiple Sclerosis	□ Yes □ Past
Parkinson's Disease	□ Yes □ Past
Dementia	□ Yes □ Past
Cancer	
Lung	□ Yes □ Past
Breast	□ Yes □ Past
Colon	□ Yes □ Past
Ovarian	□ Yes □ Past
Prostate	□ Yes □ Past
Skin	□ Yes □ Past
Other:	□ Yes □ Past

FAMILY HEALTH HISTORY

Please share with us information about the health of your immediate family members.

	Relationship		Relationship
Cancer		Mental Disorder	
Depression		Anxiety	
Heart Disease		Asthma	
Hypertension		Allergies	
Obesity		Eczema	
Diabetes		ADHD	
Stroke		Autism	
Autoimmune Disease		Irritable Bowel Syndrome	
Arthritis		Dementia	
Kidney Disease		Substance Abuse	
Thyroid Problems		Genetic Disorders	
Seizures/Epilepsy		Other:	

Family Member	Age	Present Health		Age at death	Year of death	Cause of Death
Father						
Mother						
□ Brother □ Sister						
□ Brother □ Sister						
□ Brother □ Sister						
Child 1						
Child 2						
Child 3						

SURGERIES AND HOSPITALIZATIONS

Please list all surgeries, hospitalizations, or other medical procedures you have had.

Reason/diagnosis	Year	Physician	Hospital

Have you ever had a broken bone or other orthopedic injury? If Yes, please explain. (e.g. Motor Vehicle Accident, Head Injury, Slip & Fall, etc) □ Yes □ No

Injury	Date	Details/Comments

DIAGNOSTIC STUDIES

Please indicate if you have had any of the following diagnostic studies, providing dates and test results as applicable.

Diagnostic	Date	Results/Comments
Bone Density Scan		
CT Scan		
Colonoscopy		
Cardiac Stress Test		
EKG		
MRI		
Upper Endoscopy		
Upper GI Series		
Chest X-Ray		
Other X-Rays		
Barium Enema		
Other:		
Other:		
Other:		

ALLERGIES/SENSITIVITIES

Please indicate if you have any allergies or sensitivities. These can include medications, foods, environmental, animals, chemicals, pollutants, or other substances to which you adversely react.

Substance	Age of Onset	Reaction

ADDITIONAL MEDICATIONS AND SUPPLEMENTS

Please list all current prescription medications, over the counter drugs, supplements, and vitamins you take regularly that were not previously listed in earlier sections. Please include any you have taken in the past 3 months.

Medication/OTC/Supplement	Dosage	Frequency	Last Taken

Have you ever had IV or injectable vitamin therapy? ◻ Yes ◻ No If yes, when? ___________________

Have you had prolonged or regular use of NSAIDs (Advil, Aleve, etc.) Motrin, Aspirin? ◻ Yes ◻ No

Have you had prolonged or regular use of Tylenol? ◻ Yes ◻ No

Have you had prolonged or regular use of acid blocking drugs (Zantac, Prilosec, etc? ◻ Yes ◻ No

Are you allergic to any medications or supplements? ◻ Yes ◻ No

Have you ever experienced any adverse or unusual side effects from medications or supplements? ◻ Yes ◻ No

If Yes to either question, please list them below.

Medication/OTC/Supplement	Reaction

Have you ever taken antibiotics? If yes, please indicate how often and reasons below. ◻ Yes ◻ No

Age	< 5 times	> 5 times	Reasons for Use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics? If yes, please explain below. ◻ Yes ◻ No

____

How often have you taken oral steroids (e.g., Cortisone, Prednisone, etc.)?
If yes, please indicate how often and reasons below. ◻ Yes ◻ No

Age	< 5 times	> 5 times	Reasons for Use
Infancy/Childhood			
Teen			
Adulthood			

WEIGHT HISTORY

Please tell us about your current and past weight history

Present ______________ 1 year ago ____________ 5 years ago _____________

Highest ______________ Lowest ______________ Ideal ______________

Were there any circumstances surrounding extremes of weight? If yes, please explain. ◻ Yes ◻ No

____

SYMPTOM REVIEW (Physiology and Function)

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis and treatment plan. Please indicate symptoms that occur presently or in the past six months by indicating their severity.

1 = Mild   2 = Moderate   3 = Severe

General	
Cold Hands and Feet	
Cold Intolerance	
Daytime Sleepiness	
Difficulty Falling Asleep	
Early Waking	
Fatigue	
Fever	
Flushing	
Heat Intolerance	
Night Waking	
Nightmares	
No Dream Recall	
Low Body Temperature	
Head, Eyes, and Ears	
Conjunctivitis	
Distorted Sense of Smell	
Distorted Taste	
Ear Fullness	
Ear Ringing/Buzzing	
Eye Crusting	
Eye Pain	
Headache	
Hearing Loss	
Hearing Problems	
Lid Margin Redness	
Migraine	
Sensitivity to Noises	
Vision Problems	
Musculoskeletal	
Back muscle spasm	
Calf cramps	
Chest tightness	
Foot cramps	
Joint deformity	
Joint pain	
Joint redness	
Joint stiffness	
Muscle pain	
Muscle spasms	
Muscle stiffness	
Muscle twitches:	
Around eyes	
Arms or legs	
Muscle weakness	
Neck muscle spasm	

Tendonitis	
Tension headache	
TMJ problems	
Mood/Nerves	
Agoraphobia	
Anxiety	
Auditory hallucinations	
Black-out	
Depression	
Difficulty:	
Concentrating	
With balance	
With thinking	
With judgment	
With speech	
With memory	
Dizziness (spinning)	
Fainting	
Fearfulness	
Irritability	
Light-headedness	
Numbness	
Other Phobias	
Panic attacks	
Paranoia	
Seizures	
Suicidal thoughts	
Tingling	
Tremor/trembling	
Visual hallucinations	
Cardiovascular	
Angina/chest pain	
Breathlessness	
Heart attack	
Heart murmur	
High blood pressure	
Irregular pulse	
Mitral valve prolapse	
Palpitations	
Phlebitis	
Swollen ankles/feet	
Varicose veins	
Urinary	
Bed wetting	
Hesitancy	
Infection	

Kidney disease	
Kidney stone	
Leaking/incontinence	
Pain/burning	
Prostate enlargement	
Prostate infection	
Urgency	
Digestion	
Anal spasms	
Bad teeth	
Bleeding gums	
Bloating of:	
Lower abdomen	
Whole abdomen	
Bloating after meals	
Blood in stools	
Burping	
Canker sores	
Cold sores	
Constipation	
Cracking at lip corners	
Dentures w/poor chewing	
Diarrhea	
Difficulty swallowing	
Dry mouth	
Farting	
Fissures	
Foods "repeat" (reflux)	
Heartburn	
Hemorrhoids	
Intolerance to:	
Lactose	
All dairy products	
Gluten (wheat)	
Corn	
Eggs	
Fatty foods	
Yeast	
Liver disease/jaundice	
Lower abdominal pain	
Lower abdominal pain	
Mucus in stools	
Nausea	
Periodontal disease	
Sore tongue	
Strong stool odor	

Undigested food in stools	
Upper abdominal pain	
Vomiting	
Respiratory	
Bad breath	
Bad odor in nose	
Cough - dry	
Cough - productive	
Hay fever:	
Spring	
Summer	
Fall	
Change of season	
Hoarseness	
Nasal stuffiness	
Nose bleeds	
Post nasal drip	
Sinus fullness	
Sinus infection	
Snoring	
Sore throat	
Wheezing	
Winter stuffiness	
Nails	
Bitten	
Brittle	
Curve up	
Frayed	
Fungus - fingers	
Fungus - toes	
Pitting	
Ragged cuticles	
Ridges	
Soft	
Thickening of:	
Finger nails	
Toenails	
White spots/lines	
Lymph Nodes	
Enlarged/neck	
Tender/neck	
Other enlarged/tender lymph nodes	
Eating	
Binge eating	
Bulimia	
Can't gain weight	
Can't lose weight	
Carbohydrate craving	
Carb intolerance	
Poor appetite	
Salt cravings	
Frequent Dieting	

Sweet Cravings	
Caffeine Dependency	
Skin Problems	
Acne on back	
Acne on chest	
Acne on face	
Acne on shoulders	
Athlete's foot	
Bumps on back of upper arms	
Cellulite	
Dark circles under eyes	
Ears get red	
Easy bruising	
Eczema	
Herpes - genital	
Hives	
Jock itch	
Lackluster skin	
Moles w color/size change	
Oily skin	
Pale skin	
Patchy dullness	
Psoriasis	
Rash	
Red face	
Sensitive to bites	
Sensitive to poison ivy/oak	
Shingles	
Skin cancer	
Skin darkening	
Strong body odor	
Thick calluses	
Vitiligo	
Itching Skin	
Anus	
Arms	
Ear canals	
Eyes	
Feet	
Hands	
Legs	
Nipples	
Nose	
Penis	
Roof of mouth	
Scalp	
Skin in general	
Throat	

Skin, Dryness of	
Eyes	
Feet	
Any cracking?	
Any peeling?	
Hair	
And unmanageable?	
Hands	
Any cracking?	
Any peeling?	
Mouth/throat	
Scalp	
Any dandruff?	
Skin in general	
Male Reproductive	
Discharge from penis	
Ejaculation problem	
Genital pain	
Impotence	
Infection	
Lumps in testicles	
Poor libido (sex drive)	
Female Reproductive	
Breast cysts	
Breast lumps	
Breast tenderness	
Ovarian cyst	
Poor libido (sex drive)	
Endometriosis	
Fibroids	
Infertility	
Vaginal discharge	
Vaginal odor	
Vaginal itch	
Vaginal pain	
Premenstrual:	
Bloating	
Breast tenderness	
Carbohydrate craving	
Chocolate craving	
Constipation	
Decreased sleep	
Diarrhea	
Fatigue	
Increased sleep	
Irritability	
Menstrual:	
Cramps	
Heavy periods	
Irregular periods	
No periods	
Scanty periods	
Spotting between	

WOMEN'S HISTORY (FOR WOMEN ONLY):

Obestric History: *Check box if applicable and provide number*

□ Pregnancies ____ □ Miscarriages ____ □ Abortions ____ □ Living Children ____

□ Vaginal Deliveries ____ □ Cesarean ____ □ Term Births ____ □ Premature Births ____

Birth weight of largest baby ____ Birth weight of smallest baby ____

Did you develop any problems in or after pregnancy? If yes, please comment: □ Yes □ No

____

Menstrual History:

Age at first period ____ Date of last period ________ Length of cycle ______ Time between cycles ____

Menstrual Pain? □ Yes □ No Menstrual Cramping? □ Yes □ No

Do you experience PMS symptoms? If yes, please explain below. □ Yes □ No

____

Do you have other problems with your periods (heavy, irregular, spotting, etc)? If yes, describe. □ Yes □ No

____

Are you in peri- or pre-menopause? □ Yes □ No If yes, what are your symptoms? ____________________

Are you in menopause? □ Yes □ No If yes, age at last period: ____________________

If it was surgical menopause, explain surgery: ____

Do you currently have symptomatic problems with menopause? Check if applicable

□ Hot Flashes □ Mood Swings □ Concentration/ Memory Problems □ Vaginal Dryness □ Joint Pain

□ Headaches □ Weight Gain □ Loss of Control of Urine □ Decreased Libido □ Palpitations

Are you on Hormone Replacement Therapy? □ Yes □ No If yes, for how long? ________________

For what reason are you on HRT? (hot flashes, osteoporosis prevent, etc) ________________________________

Birth Control Methods

Which forms of contraception have you used now, or in the past? Check all that apply.

□ Pill □ Patch □ NuvaRing □ IUD □ Diaphragm □ Condoms □ Partner Vasectomy

Have you had any problems with a form of birth control? If yes, please describe below. □ Yes □ No

____

General Gynecologic Health

Do you have any of these other gynecological conditions? Check if applicable

□ Endometriosis □ Infertility □ Fibrocystic Breasts □ Vaginal Infections □ Fibroids □ Ovarian Cysts

□ Pelvic Inflammatory Disease □ Reproductive Cancer □ STDs __________________

Gynecological Screening/Procedures

Last Pap Test: □ Normal □ Abnormal Date: _______________

Last Mammogram: □ Normal □ Abnormal Date: _______________

Last Bone Density: □ High □ Low □ Normal Date: _______________

Other Tests/ Procedures	Type	Date	Results

MEN'S HISTORY (FOR MEN ONLY)

Do you have any of the following health conditions? Check all applicable.

□ Testicular Mass □ Testicular Pain □ Prostate Enlargment □ Prostate Infection
□ Change in Libido □ Impotence □ Vasectomy □ Premature Ejaculation
□ Difficulty obtaining an erection □ Difficulty maintaining an erection
□ Loss of Control of Urine □ Urinary urgency/hesitancy/change in stream
□ Urination at Night # of time per night ___ □ STDs (describe) ______________________________

Screening/Procedures

Last PSA Test: PSA Level: □ 0-2 □ 2-4 □ 4-10 □ >10 Date: _______________

Other Tests/ Procedures	Type	Date	Results

BIRTH/CHILDHOOD HISTORY

Tell us about your birth. Check all boxes that apply. □ Term □ Premature □ Vaginal □ C-section

Were there any pregnancy or birth complications? If yes, please explain. □ Yes □ No

____

Tell us about your early diet: □ Breastfed How long? ______ □ Bottle Fed Type of Formula ________

Age of Introduction of: Solid Food __________ Wheat ____________ Diary __________

As a child, were there any foods that were avoided because they gave you symptoms? If yes, explain below. □ Yes □ No

____

Did you eat a lot of sugar or candy as a child? □ Yes □ No Processed foods? □ Yes □ No

ENVIRONMENTAL/DETOXIFICATION HISTORY

Do any of these significantly affect you? □ Cigarette Smoke □ Perfume/Colognes
□ Auto Exhaust Fumes □ Other: ____

Do you have regular exposure to any of the following: *(check all that apply)*

□ Mold □ Water leaks □ Renovations □ Old paint
□ Paints □ Damp environments □ Carpets or rugs □ Herbicides
□ Pesticides □ Regular contact with smokers □ Cleaning chemicals □ Airplane travel
□ Stagnant or stuffy air □ Electromagnetic Radiation □ Harsh chemicals (solvents, glues, acids, etc)
□ Heavy metals (lead, mercury, etc) □ Other: ______________________________

Is there history of a significant exposure to any harmful chemicals? □ Yes □ No

If yes: Chemical name, length of exposure, date: ____

Do you have any pets or farm animals? □ Yes □ No If yes, where do they live? □ Inside □ Outside □ Both

SLEEP

How many hours of sleep do you get each night on average? □ Less than 4 □ 4-6 □ 7-8 □ More than 8

Do you have problems with: □ Falling asleep? □ Staying asleep? □ Snoring? □ Insomnia?

Do you feel rested upon awakening? □ Yes □ No

Do you use sleeping aids? □ Yes □ No Explain: _________________________________

EXERCISE

Do you exercise? □ Yes □ No If NO, please explain: ________________________________

If YES, how often? □ 1x/wk or less □ 2-3x/wk □ 3-5x/wk □ 5-7x/wk

Activity	Type	# of Time Per Week	Duration (minutes)
Cardio/Aerobic			
Strength			
Stretching			
Sports/Leisure (ie golf)			
Other:_______________			

Are you now more or less capable physically than you were at age 17-18? □ More □ Same □ Less

Do you feel motivated to exercise? □ Yes □ A Little □ No

Are there any problems that limit exercise? □ Yes □ No

If yes, explain: ____

Do you feel unusually fatigued or sore after exercise?

If yes, explain: ____

NUTRITION

Do you feel you have a healthy diet and eating habits? □ Yes □ No

Do you currently follow any of the following special diet or nutritional program? Check all that apply

□ Vegetarian □ Vegan □ Allergy □ Elimination □ Low Fat
□ Low Carb □ High Protein □ Blood Type □ Low sodium □ No Dairy
□ No Wheat □ Gluten Free □ Other: ________________________________

Do you adversely react to: *Check all that apply*

□ MSG □ Artificial sweeteners □ Cheese □ Citrus foods □ Preservatives
□ Chocolate □ Alcohol □ Red Wine □ Sulfites □ Food Colorings

Do you have sensitivities to any foods other than above? If yes, list food and symptoms: □ Yes □ No

____

Do you have a severe dislike of certain foods? If yes, please explain below: □ Yes □ No

____

Are there any foods that you crave or binge on? If yes, please list foods below: □ Yes □ No

____

How many meals do you eat a day, including snacks? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 or more

Does skipping a meal greatly affect you? □ Yes □ No If yes, explain: ________________________

Check the factors that apply to your current lifestyle and eating habits:

□ Fast Eater □ Eat too much □ Late night eating
□ Dislike healthy foods □ Time constraints □ Travel frequently
□ Eat out more than 50% of meals □ Healthy foods not readily available □ Poor snack choices
□ Eat because I have to □ Love to eat □ Eat too little under stress
□ Emotional eater □ Struggle with eating issues □ Eat too much under stress
□ Don't care to cook □ Don't know how to cook □ Confused about nutrition advice
□ Significant other or family members don't like healthy foods □ Significant other or family members have special dietary needs □ Have negative relationship with food

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

How many servings do you eat in a typical week of each food type:

Fruits (not juice) _____	Vegetables_____	Starches/Carbs _____	Legumes (beans, peas, etc) _____
Red Meat _____	Poultry _____	Fish _____	Pork ______
Dairy _____	Wheat/Gluten _____	Sweets _____	Cans of soda (regular or diet) _____
Eggs _____	Nuts ______	Fried foods _____	Other Sugary drinks _____

Do you drink caffeinated beverages? If yes, check amounts: ☐ Yes ☐ No

Coffee (cups per day) ☐ 1 ☐ 2-4 ☐ >4

Tea (cups per day) ☐ 1 ☐ 2-4 ☐ >4

Caffeinated sodas - regular or diet (cans per day) ☐ 1 ☐ 2-4 ☐ >4

Do you have adverse reactions to caffeine? If yes, please check applicable symptoms below. ☐ Yes ☐ No

☐ Irritable or Wired ☐ Aches or Pains ☐ Other: ____________________

DIET

Please record what you eat in a typical day:

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Fluids ____

SMOKING/ALCOHOL/DRUG HISTORY

Do you currently smoke or chew tobacco? ☐ Yes ☐ No

If yes, how much/often? ___________________ How many years? ___________________

What type? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cig ☐ Other _________________

Have you attempted to quit? ☐ Yes ☐ No What methods have you tried? ____________________

Did you smoke/chew previously? ☐ Yes ☐ No If yes, packs per day: _____ Number of years ______

Do you have regular second hand smoke exposure? ☐ Yes ☐ No

How many alcoholic beverages do you drink in a week? ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 ☐ None

Type(s): ☐ Beer ☐ Wine ☐ Spirits ☐ Mixed Drinks ☐ Other

Have you ever had a problem with alcohol? ☐ Yes ☐ No If yes, when? ____________

Explain: ____

Did you stop drinking as a result? ☐ Yes ☐ No If yes, when? ____________

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

Have you ever or are you currently using any recreational drugs? ☐ Yes ☐ No

If yes, how much/often? ______________________ How many years? ______________________

Type(s): ____

How long has it been since you last used any drugs? ______________________________

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

Have you ever been addicted to any prescription drugs? If yes, please explain below. ☐ Yes ☐ No

____

Have you ever received treatment for addiction to drugs or alcohol? ☐ Yes ☐ No

If yes, when? ________________ Where? ______________________ For what? ____________________

STRESS

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

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

How much stress do each of the following cause on a daily basis? *(Rate on scale of 1-10, 10 highest)*

Work ___ Family ___ Social ___ Finances ___ Health ___ Other ____

Do you use relaxation techniques? ☐ Yes ☐ No If yes, how often? ____________________________

Which techniques do you use? Check all that apply

☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Other _____

Have you ever sought counseling? ☐ Yes ☐ No Are you currently in therapy? ☐ Yes ☐ No

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

What are your hobbies or leisure activities? ____

How well have things been going for you?

Overall	☐ Very Well	☐ Fine	☐ Poorly	☐ N/A
At school	☐ Very Well	☐ Fine	☐ Poorly	☐ N/A
In your job	☐ Very Well	☐ Fine	☐ Poorly	☐ N/A
In your social life	☐ Very Well	☐ Fine	☐ Poorly	☐ N/A
With close friends	☐ Very Well	☐ Fine	☐ Poorly	☐ N/A
With sex	☐ Very Well	☐ Fine	☐ Poorly	☐ N/A
With your attitude	☐ Very Well	☐ Fine	☐ Poorly	☐ N/A
With your significant other	☐ Very Well	☐ Fine	☐ Poorly	☐ N/A
With your children	☐ Very Well	☐ Fine	☐ Poorly	☐ N/A
With your parents	☐ Very Well	☐ Fine	☐ Poorly	☐ N/A
With your spouse	☐ Very Well	☐ Fine	☐ Poorly	☐ N/A

LIFE EVENTS AND LIFE CONTEXT

Briefly describe any major life events or health events you have experienced. Include: compatibility between parents, between parents and children, health crisises, onset of health conditions, or significant traumas-emotionally, mentally, or physically,- and any other information you feel is important to your health journey.

Early Childhood: *Age 0-5*	
Childhood: *Age 5-10*	
Adolesence: *Age 11-17*	
Early adulthood: *Age 18-24*	
Recent years: *Age 25+*	

RELATIONSHIPS

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partner ☐ Widow

With whom do you live? ____

Current Occupation: ________________ Previous Occupations: ____________________________

Do you have resources for emotional support? ☐ Yes ☐ No Whom? ___________________________

Do you have a religious or spiritual practice? □ Yes □ No If yes, what kind? ___________________

How would you describe the quality of your relationships with people in general (including coworkers)?

□ Fulfilling □ Amicable □ Neutral □ Awkward □ Unhappy □ Tumultous

How would you describe the quality of your relationships with your family and in-laws?

□ Loving □ Amicable □ Neutral □ Distant □ Strained □ Non-existant

Who are the most important people in your life?

Name	Relationship	Name	Relationship

SUMMARY

What do you hope to achieve in your visit with us? ____

____

When was the last time you felt well? ____

Did something trigger your change in health? ____

What makes you feel better? ____

What makes you feel worse? ____

How does your condition affect you? ____

____

What do you think is happening and why? ____

____

On a scale of 1 to 5, with 1 being *not ready* and 5 being *completely ready*, how prepared are you to make significant changes to your lifestyle at this time? □ 1 □ 2 □ 3 □ 4 □ 5

Explain: ____

ACKNOWLEDGEMENTS AND CONSENT

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initial

____ **I instruct the health care practitioner to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the health care offered in this practice is based on the best available evidence.**

____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Patient: _______________________________________ Date: ____________________