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Please complete the following questionnaire as thoroughly as possible. This will aid the Practitioner in making appropriate recommendations for you. This document will become a part of your confidential medical record and will not be released without your authorization.

PLEASE PRINT CLEARLY

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____ Age: _____ Gender: _____

Address:

_____

(Number, street, apt number, city, state, and postal code)

Home Phone: _____ Employer: _____ Work Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Email Address_____

How did you hear about us: _____

Insured Patient's Company Name: _____Policy Number: _____

(Fill out if different from above. (You are not the primary name on the policy) Insured Person's date of Birth _____

Insured Patients Name: _____ Employer: _____

Present Health Concerns (in order of importance): Duration:

1. _____ _____

2. _____ _____

3. _____ _____

4._____ _____

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Social History (Please circle, or complete if applicable):

Single/ Married / Significant other Name of husband/wife/partner: _____

Your occupation: _____ Your Education: _____

Children (names ages)_____

Known Allergies [drugs food environmental (grass, pollen, etc.)]:

_____

List any chemicals, fumes, dusts etc. that you are or have been repeatedly exposed to: _____

Vitamins/Herbs/Supplements Currently Taking:

Name/Type	Reason for taking	Dose/day (mg/etc)	For how long	Who prescribed

Current Medications (prescription <u>and</u> over the counter

Name of drug	Reason for drug	Dose/day (mg/etc)	For how long	Prescribing Dr.

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Name of drug	Reason for drug	Dose/day (mg/etc)	For how long	Prescribing Dr.

List additional medications here:

Regular Exercise (complete if applicable):

Types of exercise Dance/weights /Yoga / Aerobics	Times/ session (min/hours/etc)	Frequency (daily wkly)	Practiced for how long

Sleep Habits:

How many hours/night: _____ Do you wake refreshed? ____ If no why _____

Do you have problems (circle) Falling asleep /Staying asleep/ Waking up

Average energy level per week (circle one):

1 2 3 4 5 6 7 8 9 10
(Lowest) (Highest)

Average Stress Level per week (circle one):

1 2 3 4 5 6 7 8 9 10
(Lowest) (Highest)
How do you cope with stress? _____

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Do you talk to anyone about your problems? _____Who? _____

Who else might you confide in or seek advice from? _____

What are some things you do for fun and how often? _____

_____

Diet History (include any liquids tea, coffees. in description; in the table below, list number of servings):

What was lunch yesterday? _____

What was breakfast yesterday? _____

What was dinner yesterday? _____

List snacks you had yesterday _____

How many glasses of plain water do you drink per day? _____Filtered, tap, distilled, well water

Any special diet restrictions? _____

	Never	Occasionally	Weekly	Daily
Red Meat Beef, goat, deer etc				
Fish				
Chicken / Turkey				
Fresh Fruits				
Vegetables				
Dairy Products Milk, cheese etc.				
Whole Grains				
Sweets Pastries, candies etc.				
Vegetables				

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Medical /Health History:

Primary Care Doctor/provider (if any): _____ Date last seen_____

Reason for seeing:_____

Office Name:_____ Doctor's Phone number: _____

Doctors full address: _____

Other Current provider(s) name	Type	for what health Reason	Phone

Date of last full physical exam: _____ Results: Normal, Other _____

Date of last Urine Test: _____ Results: Normal, Other _____

Date of last Blood work: _____ Results: Normal, Other _____

Date of last PAP/pelvic exam (females): _____ Results :_____

Date of last mammogram (females over 40): Findings : _____

Are you pregnant (females)? _____ if so, how far along are you? _____

Date of last prostate exam (males): Results: _____

How would you describe your general health? _____

Outpatient procedures/Hospitalizations (surgery/special diagnostic studies):

Type (of surgery)	Date	Reason for procedure	Out/Results

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Major Illnesses/emotional or physical trauma/accidents (if not already listed):

Type	Date	Treatment Received	Outcome

Eliminations (please complete):

	Bowel Movements		**Urine habits**
Frequency How often		How often per 24 hrs	
Color (black, brown yellow, white)		Color (dark yellow, light yellow, colorless green	
Consistency (hard, formed, soft watery)		Character (clear, cloudy, concentrated, dilute)	
Any mucus or blood?		Any blood or sediment?	
Does it pass easily? any straining involved		Does it pass easily	

Personal Habits (check or describe in the following boxes):

	Tobacco	Alcohol	Caffeine	Recreational drugs
Currently Use;				
Previously used				
Never Used				
How much/many: per day/week etc.				
For how long: Months/years)				
Date quit				

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Review of Systems (check if you've had any of the following):

- ❑ Anemia
- ❑ blood disease
- ❑ fatigue (affecting daily living)
- ❑ dizziness (more than five seconds
- ❑ frequent headaches
- ❑ loss of hearing
- ❑ ringing in ears (more than five seconds
- ❑ loss of vision
- ❑ eye pain
- ❑ frequent sore throats
- ❑ lasting numbness
- ❑ lasting weakness
- ❑ lasting tingling
- ❑ nervousness/depression
- ❑ skin problems
- ❑ brittle nails
- ❑ hair loss
- ❑ allergies
- ❑ Asthma
- ❑ difficulty breathing
- ❑ chronic bronchitis
- ❑ tuberculosis
- ❑ stomach ulcers
- ❑ constipation
- ❑ diarrhea (infectious)
- ❑ diarrhea (bloody)
- ❑ lasting nausea
- ❑ recurrent vomiting
- ❑ chest pain
- ❑ heart disease
- ❑ heart failure
- ❑ irregular heart beat
- ❑ hemorrhoids
- ❑ easy bruising
- ❑ frequent noose bleeds
- ❑ varicose veins
- ❑ poor circulation
- ❑ stroke
- ❑
- ❑ Kidney failure
- ❑ Kidney infection
- ❑ Kidney stones
- ❑ Sexually transmitted disease
- ❑ Thyroid disorder
- ❑ Diabetes
- ❑ Swelling of ankles
- ❑ Liver disease
- ❑ Hepatitis
- ❑ Arthritis
- ❑ Neck pain/stiffness
- ❑ Bursitis
- ❑ Hot and swollen joints
- ❑ Prostate enlargement
- ❑ Cramps/backache (females)
- ❑ Excessive menstrual flow
- ❑ Hot flushes
- ❑ Irregular cycles
- ❑ Fibrocystic breasts

Family History. Use the following key to indicate which family members have had the following conditions. List type where parenthesis is present):

M= Mother F=Father B= Brother S=Sister G=Grandparent C= Child

Condition	Whom	Condition	Whom	Condition	Whom
Allergies		Diabetes			
Alcoholism		Cancer ( )			
Anemia					
Arthritis (Rheumatoid)		Epilepsy			
Arthritis (Osteo)		Disease			
Auto Immune disease		Hepatitis			
Bleeding tendency		High Blood Pressure			

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Whole Person Health Habit Inventory

Physical

- ❑ I participate regularly (three times a week or more) in a vigorous physical exercise program.
- ❑ I eat a well balance diet
- ❑ My weight is within 10 lbs. Of the ideal weight for my height
- ❑ My alcohol consumption is seven drinks shot beer, or glass of wine)or fewer per week.
- ❑ I always wear my seat belt
- ❑ I do not smoke cigarettes , cigars or a pipe.
- ❑ I generally get adequate and satisfying sleep.

Mental

- ❑ I Seldom experience periods of depression
- ❑ I generally face up to problems and cope with change effectively.
- ❑ I worry very little about future possibilities or things I can't change.
- ❑ I laugh several times day and usually fit "play" into my schedule
- ❑ I am curious and always on the lookout for new learning
- ❑ I maintain realistic and basically positive self-image

Relational

- ❑ I seek help and support when I need it.
- ❑ I have at least one person with whom I can share almost anything
- ❑ I have nourishing intimate relationships with family and/or friends
- ❑ I express and experience a wide range of emotions and respond to others feelings appropriately
- ❑ Each day includes comfortable and stimulating interaction with others.
- ❑ I solicit and accept feedback from others
- ❑ I stick up for my self when it is necessary and appropriate.

Spiritual

- ❑ I set aside 15-20 minuets each day for prayer or meditation.
- ❑ I participate in regular spiritual rituals with people who share my beliefs.
- ❑ I accept my limitations and inadequacies without embarrassment or apology
- ❑ I keep the purpose of my life clearly in mind and let it guide my goal setting decision-making.
- ❑ I regularly offer my time and possession in service of others.
- ❑ I am sensitive to ultimate truths and spiritual dimension of life.
- ❑ I readily forgive others and myself.

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Count up you check marks for each category and record them below.

Physical _____ Relational _____

Mental _____ Spiritual _____ Total _____

- **How to interpret your score:**

The total number of checks on the **Whole Person Health Habit Inventory** provides a general idea of how well you take care of your health across all dimensions of life. Compare your total score to the health balance standards:

24-28 Excellent: Your habits are enhancing your health.

16-23 Average: You are obviously trying but there is room for improvement.

Below 16 Poor: The quality of your health is probably diminished by poor habits.

Take a few minutes to reflect on your score and your reactions to it. Use the worksheet below to record your insights and resolution for change.

Personal Reflection on My Self Care Patterns

- In what areas are my habits enhancing my health ?
  _____
  _____
- In which areas are my habits working against my health?
  _____
  _____
- In which areas would I like to make changes?
  _____
  _____
- Which particular habits would I like to modify?
  _____
  _____

What level of change to your living habits are you willing to make to improve your health? (Tick one): **Whatever it takes** **Significant change** **Some change** **No change**

Is there any thing else you want us to know about you?_____

Thank you for your time and patience in filling out this form.

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