healthy happy whole

Integrative Medicine & Wellness Center

Today's Date:

New Patient Registration

This is a CONFIDENTIAL questionnaire. Your current and past health history will be evaluated in order to provide a customized treatment plan that meets your medical and wellness goals.

Full Name ______________________ Name Preference ______________

Home Address ______________________ City ______________

State ______________ Zip ______________ Email ______________

☐ Home ( ) ______________ ☐ Work ( ) ______________ ☐ Cell ( ) ______________

Please mark above which number(s) you will prefer to receive messages. Best time to call ______ AM ______ PM

Date of Birth ______________ Age ______ Adopted ☐ Y ☐ N Sex: ☐ Female ☐ Male ☐ Trans ☐ FTM ☐ MTF

Marital Status: ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widowed Number of Children ______

Occupation ______________________ Employer ______________

Emergency Contact ______________________ Relationship ______________

Phone 1 ( ) ______________________ Phone 2 ( ) ______________________

Who may we thank for referring you? ______________________

Healthy Happy Whole will never sell or transfer your information to third parties.
May we contact you for follow up care and to share important clinic updates: ☐ Yes ☐ No
Appointment reminder preference: ☐ Email ☐ Text

Height ____ ' ____ " Weight ______ 1year ago ______ lbs. Adult Max ______ lbs. Adult Minimum ______ lbs.

Known Allergies ______________________

Blood Type: ☐ A ☐ O ☐ B ☐ AB ☐ Unknown Do you regularly donate blood? ☐ Yes ☐ No

Rh Factor: ☐ Positive ☐ Negative ☐ Unknown Have you ever had a blood or plasma transfusion? ☐ Yes ☐ No

Date of last physical exam ______________ With whom ______________________

Reported findings ______________________

Surgeries, Hopsitalizations, Serious Illnesses (List year in brackets) ______________________

____

Fractures, Dislocations, Major Dental Work (List year in brackets) ______________________

Purpose of this Appointment ______________________

Have you sought other treatment / consulted another medical professional for this condition? ☐ Yes ☐ No

If yes, what forms of treatment have you sought? ______________________ When ______________

Were the treatments helpful? ☐ Yes ☐ No Explain ______________________

Doctor's Name ______________________ Phone ( ) ______________

Address ______________ City ______________ State ______ Zip ______________

Email ______________________ ☐ You have my permission to contact my doctor

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Please list any other health concerns ______________________

What are your overall wellness goals? ______________________

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Please mark the following boxes with an **X** = Current Use ✓ = Previous Use

LIFESTYLE HABITS

☐ Caffeine # Coffee/day ________ # Sodas/day_______ ☐ Diet ☐ Regular # Tea/day ____________

☐ Alcohol # Drinks/week ________ Type ______________________ Started at Age ____Quit____

☐ Tobacco # Cigarettes/day ______ Brand ______________________ Started at Age ____Quit____

☐ Recreational Drugs: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

DIET

Food cravings ______________________________ ☐ Salty ☐ Sweet ☐ Sour ☐ Bitter ☐ Fats/Greasy

Known food sensitivities ______________________________

Mark any dietary choices that apply: ☐ Vegetarian ☐ Vegan ☐ Macrobiotic ☐ Raw ☐ Other ____________

Do you eat at restaurants? ☐ Yes ☐ No # of Times per week? ______ Where______________________

Are you currently Dieting? ☐ Yes ☐ No If yes, please describe ______________________

OTHER

Do you sleep well? ☐ Yes ☐ No Sleep ________pm/am Wake ________pm/am Average Hours/night __________

If no, please describe ______________________________

Do you have enough energy for normal activities? ☐ Yes ☐ No ______________________

Has your vision changed recently? ☐ Yes ☐ No ______________________

Bowel Frequency ________ # Times/day Difficulty ☐ Yes ☐ No ______________________

Urinary Frequency _______ # Times/day Difficulty ☐ Yes ☐ No Do you wake to urinate? ☐ Yes ☐ No ____#/night

Do you wear heel lifts or foot supports? ☐ Yes ☐ No

SYMPTOM SURVEY

Please mark the list of symptoms you: + Frequently experience ✓ Sometimes experience

___ Lack of appetite
___ Excessive appetite
___ Loose stool or diarrhea
___ Constant worry
___ Mind racing

___ Digestive problems, indigestion
___ Vomiting / Nausea
___ Ulcers
___ Feeling retention of food in the stomach
___ Difficulty concentrating

___ Heartburn, reflux
___ Belching, burping
___ Abdominal bloating
___ Irritability eased with food
___ Easily bruised

___ Insomnia
___ Heart palpitations
___ Mentally restless
___ Nightmares

___ Chest pain
___ Sciatic pain
___ Pain or coldness in the genital area
___ Abdominal pain

___ Tension headache
___ Migraine
___ Laughing for no reason

___ Cough
___ Shortness of breath
___ Decreased sense of smell
___ Nasal problems
___ Skin problems
___ Unexplained weight loss

___ Bronchitis
___ Coughing blood
___ Recent use of antibiotics
___ Phlegm: ☐ Nose ☐ Chest/cough
Easy to expectorate: ☐ Yes ☐ No
Color: ☐ Clear ☐ White ☐ Yellow ☐ Brown ☐ Green

___ Sinus Congestion
___ Allergies
___ Constipation
___ Colitis or diverticulitis
___ Hemorrhoids

___ Muscle spasms/twitching
___ Eye twitching
___ Eye problems/floaters
___ Soft, brittle nails

___ Easily angered or agitated
___ Difficulty making plans or decisions
___ Dizziness
___ Intestinal gas

___ Difficulty digesting oily foods
___ Jaundice (yellowish skin or eyes)
___ Gallstones
___ Light colored stool

___ Low back pain
___ Knee problems
___ Ear ringing
___ Hearing impairment
___ Hair loss
___ Decreased sex drive

___ Often cold, prefers warmth
___ Intolerance to weather changes
___ Asthma
___ Tendency to catch colds easily
___ Fatigue

___ Urinary problems
___ Kidney stones
___ Blood in stool
___ Black tarry stool
___ Edema

___ Acne
___ Eczema
___ Psoriasis

___ Rashes
___ Itching
___ Dandruff

___ Sweating: ☐ Easily ☐ Rarely ☐ Hot Flashes ☐ Night Sweats
___ Temperature: ☐ Cold ☐ Warm ☐ Over-heated
___ STD: ☐ HIV ☐ Herpes ☐ Gonorrhea ☐ Clamydia ☐ HPV

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MENTAL / EMOTIONAL SELF REPORT

How do you feel about your:

	Fair → Great		Fair → Great		Fair → Great
Life	1 2 3 4 5	Partner / Spouse	1 2 3 4 5 NA	Exercise	1 2 3 4 5
Health	1 2 3 4 5	Profession	1 2 3 4 5 NA	Diet	1 2 3 4 5
Family	1 2 3 4 5	Creativity	1 2 3 4 5	Spirituality	1 2 3 4 5
Relationships	1 2 3 4 5	Emotional support	1 2 3 4 5	Self	1 2 3 4 5

OB/GYN HISTORY

Age at first menstrual cycle ___________________ Are you pregnant? ☐ Yes ☐ No ☐ Uncertain

Age at menopause ___________________________ # Pregnancies______________ # Live births ________________

Number of days between periods ______________ # Abortions ________________ # Miscarriages ______________

Number of days of flow _______________________ Date of last: Gynecologic exam ___________________________

Date of last menstrual cycle___________________ Pap smear _________________ Mammorgram ______________

Color of flow:	Pale	Pink	Light red	Red	Deep red	Purple	Brown
Regularity:	Regular	Irregular	Early	Late	Varies		
Menstrual flow:	Even	Uneven	Heavy	Light			
Consistency:	Thin	Thick	Clotted				

Please circle the following symptoms according to: B = before D= during A= after

Irritability	B D A	Breast Tenderness	B D A	Lower Back Soreness	B D A
Bloating	B D A	Mood Swings	B D A	Other ______________________	
Cramping	B D A	Food Cravings	B D A	______________________	

Vaginal Discharge ☐ Yes ☐ No Color/Consistency/Amount______________________________________

Libido/Function: ____

UROGENITAL HISTORY

Date of last prostate exam ____________ PSA results __________ Manual prostate exam results _______________

Lab results____

Frequency of urination: Daytime _______ nighttime _______ Color of urine: ☐ Clear ☐ Murky Odor: ____________

Please mark the following symptoms. + Frequently experience ✓ Sometimes experience

___ Prostate problems	___ Delayed stream	___ Post void dribbling	___ Incontinence
___ Erectile dysfunction	___ Increased libido	___ Decreased libido	___ Premature ejaculation
___ Back pain	___ Groin pain	___ Testicular pain	___ Decreased force of stream
___ Urine retention	___ Impotence	___ Rectal dysfunction	___ Enlarged testicals

DIAGNOSTIC TESTING

Blood work	Date ______	Results ______________	MRI	Date _____	Results ______________________
CT scan	Date ______	Results ______________	Urinalysis	Date _____	Results ______________________
EKG	Date ______	Results ______________	X-Ray	Date _____	Results ______________________

FAMILY MEDICAL HISTORY

	You	Relative	Year		You	Relative	Year
High blood pressure	_____	___________	________	Arthritis	_____	___________	________
Heart disease	_____	___________	________	Diabetes	_____	___________	________
Emotional disorder	_____	___________	________	Gallstones	_____	___________	________
Eating disorder	_____	___________	________	Hepatitis	_____	___________	________
Neurologic disorder	_____	___________	________	Alcoholism	_____	___________	________
Seizures	_____	___________	________	Infectious disease	_____	___________	________
Alzheimers	_____	___________	________	Rheumatic fever	_____	___________	________
Thyroid disorder	_____	___________	________	Tuberculosis	_____	___________	________
Anemia	_____	___________	________	HIV/AIDS	_____	___________	________
Stroke	_____	___________	________	Cancer	_____	___________	________

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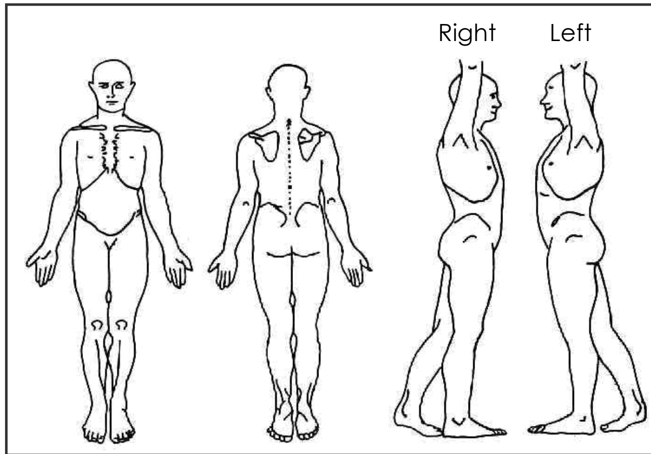
PAIN ASSESSMENT

Do you have chronic, on-going pain? ☐ Yes ☐ No

Please draw the location of your pain below. Use heavier shading in areas of more intense pain.



Initial onset (Date/Year) ____________________

Due to: Injury/trauma Auto accident Work-related Repetitive stress Other ____________________

Characteristics: Dull/Achy Sharp/Stabbing Tingling Pain moves Localized Comes & goes Constant

What activities cause/make the pain worse? ____________________

What makes it better? ____________________

MEDICATIONS

Please mark and list ALL of the medications you are currently taking.

Advil/Ibuprofen/Tylenol	Cold medication	Hormone replacement
Allergy medication	Oral contraceptive	Interferon
Antacids	Blood thinner (Coumadin/Warfarin)	Laxatives
Antibiotics	DHEA/Melatonin	Steroids
Antidepressants	Diet pills	Supplements
Aspirin	Diuretics	Sleeping pills/tranquilizers
Blood pressure medication	Herbal formulas/tinctures	Viagra/Cialis

List the names of ALL medications/supplements you are currently taking (continue on the back if necessary):

Medicine/Dosage	Reason	How Long	Prescribed by	Last appointment

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PATIENT PROFILE

Have you received acupuncture/dry needling before? ☐ Yes ☐ No If so, when? ____________________

With whom? ____________________

☐ Licensed Acupuncturist/DAOM ☐ Doctor / Chiropractor ☐ Other ____________________

MEDICAL REMINDER

I have a Pacemaker	I have Allergies to ____________	I am Pregnant; I am in Trimester 1 2 3
I have Hemophilia	I am taking a Blood Thinner (Coumadin/Warfarin)	I am taking Anti-seizure Medication

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PATIENT CONSENT

The above information is accurate and true to the best of my knowledge. I understand that an office visit may include a variety of therapeutic modalities such as physiotherapy, acupuncture therapies, manual therapy, medical massage, dietary and nutritional counseling, herbal therapy, cold and/or heat therapy, Qi Gong, or other therapeutic exercise.

I understand that I am responsible for full payment for any and all scheduled appointments, including missed and cancelled appointments without 24 hours notice. I have read and agree to all terms of the cancellation policy.

I take responsibility for alerting my practitioner to any physical or emotional changes that occur with my health. If I have any questions or concerns before, during or after any treatment, I will bring them to the attention of the practitioner.

Patient Signature ____________________ Printed Name ____________________ Date __________

Practitioner Signature ____________________ Printed Name____________________ Date __________

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