Health Status Intake

Please fill out and return

This is a confidential record of your medical history. It will not be released except when you have authorized us to do so or we are required to by law. Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible; it will help you to get the most from your visits. Mark anything that you do not understand with a question mark. Thank you.

Name: ____ Date: ___________

Address: ____

City: __________________________ State: _______________ Zip Code: _____________

Telephone # (home):__________________ (work): _______________ (cell):________________

May we leave confidential voice-mail messages for you at any of the above numbers? No / Yes (specify): **Home / Work / Cell**

E-mail address: ____

May we leave confidential E-mail messages for you at the above address? No / Yes

______ **(initials) I understand that email is inherently unsecure and that it is possible if my personal health information is sent over email that it may be viewed by others. I recognize and accept this possibility and authorize my doctor to communicate facets of my personal health information with me over email.**

Date of Birth: __________________________ Gender: female / male / other

Education: ____

Relationship status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership
Live with: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone
Employment status: ☐ Full-time ☐ Part-time ☐ School ☐ Retired ☐ Unemployed ☐ Other_______
Occupation: ____ Hours per week: _________

Employer: __________________________________ S.S.#: __________________________

How did you hear about our clinic? ____

____

Has any other family member already been a patient at the clinic? ___________________________

Emergency contact: ____

Relationship: ___________________________ Phone: ______________________________

Address: ____

Health Status Interview

Please fill out and return

1) What <u>long term</u> expectations do you have for working with our clinic?

2) What expectations do you have of me personally as your physician?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle?
0% 0 - - - 1 - - - 2 - - - 3 - - - 4 - - - 5 - - - 6 - - - 7 - - - 8 - - - 9 - - - 10 100%

4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that we will be sharing with you?

6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Health Status Interview

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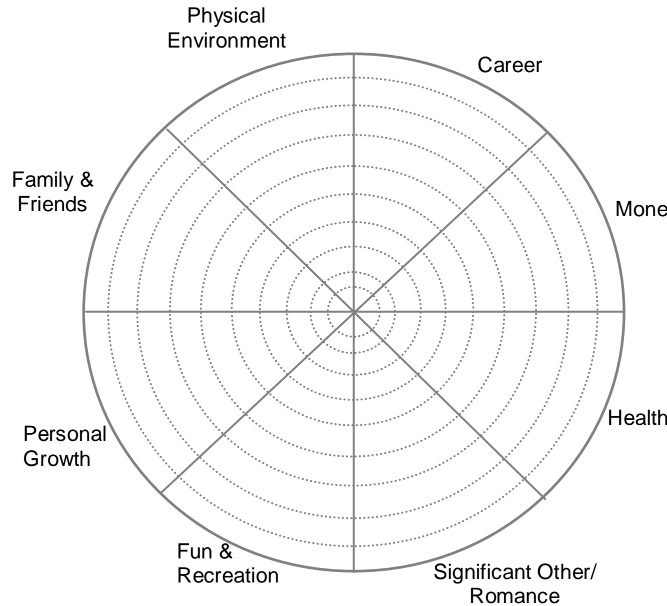
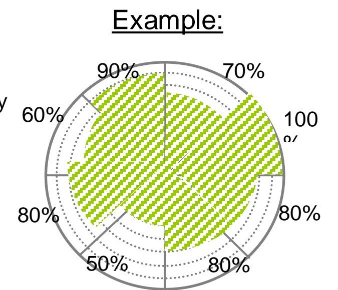
Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.





Who, if any, healthcare providers do you see? (please include provider name and business name)_______
____
____
____

What do you consider your most important health issues? List in order of importance:

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

Health Status Interview

Please fill out and return

Do you have any known contagious diseases at this time? Y N

If yes, what? ____

Family History

Member	Age	Important diseases	Living?	Cause of death
Mother				
Father				
Siblings				
Siblings				
*MGM				
*MGF				
*PGM				
*PGF				

M = Maternal (Mother) P = Paternal (Father) GM = Grandmother GF = Grandfather

Any other relevant family history? ____

____

What is your ethnic background? ____

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

__________________________ year: ________ __________________________ year: ________

__________________________ year: ________ __________________________ year: ________

__________________________ year: ________ __________________________ year: ________

Accidents/Injuries (briefly describe)

More than 5 years ago ____

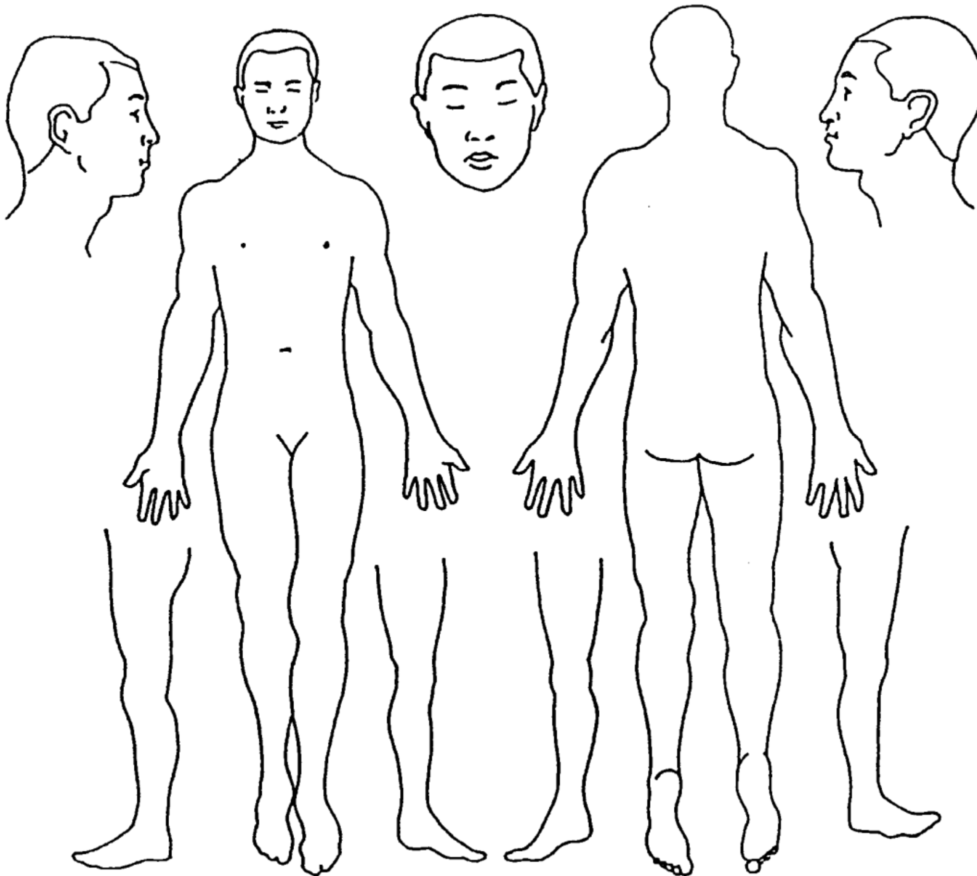
Less than 5 year ago ____

ASPIRE NATURAL HEALTH
Work better. Play better. Live better.

Health Status Interview

Please fill out and return

PAIN
DO YOU HAVE ANY PAIN(S)? ☐ Yes ☐ No
Please indicate painful or distressed areas



AREA/DESCRIPTION OF SYMPTOMS	PAIN LEVEL: 0 TO 10 (10 most painful)	FREQUENCY
______________________	______________	____________
______________________	______________	____________
______________________	______________	____________
______________________	______________	____________
______________________	______________	____________

Health Status Interview

Please fill out and return

Allergies

Are you hypersensitive or allergic to...
Any drugs? ____

Any foods? ____

Any environmentals or chemicals? ____

To the best of your knowledge have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation or other toxins beyond those encountered in daily life? ______________________________
Details ____

Current Medications

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N
Birth control pills	Y N				

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking. Please include the brand and dosage. If you need more room please write on the back of the form or include an attached sheet.

1)____ 7) ____
2)____ 8) ____
3)____ 9) ____
4)____ 10) _______________________________________
5)____ 11) _______________________________________
6)____ 12) _______________________________________

General

Height: __________________Weight:__________________ lbs. Weight 1 year ago: __________lbs.
Maximum Weight : __________________ When: ____
When during the day is your energy the best? _______________ worst? _____________________

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Health Status Interview

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Typical Food Intake

Dietary preferences/restrictions: ____

What is your favorite food? ______________________ Favorite flavor? ____________

Sample Day's menu (Please fill out a true sample day, and not what you think we would like you to put. We do not judge your food choices, our goal is to help adjust your food intake to best help you)

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To drink: ____

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Habits

Main interests and hobbies?____

Do you exercise? Y N

If yes, what kind?______________________ How often? ____________

Average amount of sleep per night ________		Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	Watch television?	Y N
Have a history of abuse?	Y N	how many hours? ______	
Any major traumas?	Y N P	Read?	Y N
Use recreational drugs?	Y N P	how many hours? ______	
Been treated for drug dependence?	Y N P		
Use alcoholic beverages?	Y N P	Do you eat 3 meals a day?	Y N
Treated for alcoholism?	Y N P	Do you go on diets often?	Y N
Do you currently use tobacco?	Y N P	Do you eat out often?	Y N
Smoked previously?	Y N P	Do you drink coffee?	Y N P
How many years? ____________		Drink black/green tea?	Y N P
How many packs per day? ____________		Do you drink cola/other sodas?	Y N P
		Do you eat refined sugar?	Y N P

Health Status Interview

Please fill out and return

Do you add salt? Y N P

Do you have a religious or spiritual practice? Y N If yes, what?________________________________

REVIEW OF SYSTEMS

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Mental / Emotional

Treated for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Tension?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P

Immune

Frequent infections?	Y N P	Reactions to vaccinations?	Y N P
Chronic Fatigue Syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

Endocrine

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Skin

Skin ☐ Nσmal ☐ Dry ☐ Oily		Rashes?	Y N P
Eczema	Y N P	Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P
Color Change?	Y N P	Perpetual Hair Loss?	Y N P
Lumps?	Y N P	Night Sweats?	Y N P

Health Status Interview

Please fill out and return

Y=a condition you have now	**N=**Never had	**P=**Significant problem in the past

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P

Eyes

Spots in Eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hay fever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P

Health Status Interview

Please fill out and return

Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	Shortness of breath lying down?	Y N P
Tuberculosis?	Y N P		

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Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic Fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? ___________	
Gall Bladder disease?	Y N P	Is this a change?	Y N
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P

Health Status Interview

Please fill out and return

Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Male Reproduction

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Venereal disease?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N	Chlamydia?	Y N P
Sexual orientation: ______________________		Gonorrhea?	Y N P
Impotence?	Y N P	Genital warts?	Y N P
Premature ejaculation?	Y N P	Herpes?	Y N P
Birth control? Type? ____________________		Syphilis?	Y N P

Female Reproduction / Breasts

Age of first menses? ______________________		Date of last annual exam/ PAP ___________	
Age of last menses? (if menopausal) _________		Are cycles regular?	Y N
Length of cycle? ______________ days		Bleeding between cycles?	Y N P
Duration of menses? ______________ days		Pain during intercourse?	Y N P
Painful menses?	Y N P	Clotting?	Y N P
Heavy or excessive flow?	Y N P	Discharge?	Y N P
PMS?	Y N P	Birth control?	Y N P
If yes, what are your symptoms?		What type? ________________________	
____________________________________		Number of pregnancies: ______________	
____________________________________		Number of live births: ______________	
Endometriosis?	Y N P	Number of miscarriages: ______________	
Ovarian cysts?	Y N P	Number of abortions: ______________	
Difficulty conceiving?	Y N P	Menopausal symptoms?	Y N P
Cervical Dysplasia?	Y N P	Abnormal PAP?	Y N P
Sexual difficulties?	Y N P	Chlamydia?	Y N P
Gonorrhea?	Y N P	Genital warts?	Y N P
Herpes?	Y N P	Syphilis?	Y N P
Are you sexually active?	Y N	Sexual orientation: ________________	
Do you do breast self exams?	Y N P	Breast lumps?	Y N P
Breast pain/tenderness?	Y N P	Nipple discharge?	Y N P

Health Status Interview

Please fill out and return

Please use this space (and/or the back of the sheet or an additional sheet) to add any other information about yourself that you think will be of help to us?

Done. Thank you for your time and effort. We look forward to continuing to work with you.