Providence Wholistic Healthcare

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Client Intake and Health History

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home)_____ (cell)_____

Age _____ Date of Birth _____Gender _____Pronouns:_____

Education _____Email:_____

Married ____Partnership ____Separated ____Divorced ____ Widowed ____ Single _____

Live with: Spouse ____ Partner ____ Parents ____ Children ____ Friends ____ Alone ___

Occupation _____ Hours per week _____ Retired _____

Employer _____Work phone contact_____

Work address _____

How did you hear about our clinic? _____

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

Next of Kin or other to reach in an emergency _____

Relationship _____ Phone _____

Address _____

HEALTH HISTORY QUESTIONNAIRE

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

History of Health Condition(s):

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

_____

_____

_____

What was the reason? _____Did you get bloodwork?_____

What kind of bloodwork?_____ Bring an extra copy for the Doctor.

List your most important health problems in order of importance

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

What is your general state of health (circle one): Excellent Good Average Fair Poor

Are you currently seeing a primary care physician? Who? What are your diagnoses?

_____

Family History: indicate if you or a member of your close family have had the following

	Self	**Mother**	**Father**	**Brother**	**Sister(s)**	**Grandparents (MGP)**	**(PGP)**
Cancer	_____	_____	_____	_____	_____	___/__	___/__
Diabetes	_____	_____	_____	_____	_____	___/__	___/__
Heart Disease	_____	_____	_____	_____	_____	___/__	___/__
High Blood Pressure	_____	_____	_____	_____	_____	___/__	___/__
Stroke	_____	_____	_____	_____	_____	___/__	___/__
Epilepsy	_____	_____	_____	_____	_____	___/__	___/__
Mental Illness	_____	_____	_____	_____	_____	___/__	___/__
Asthma/Allergies	_____	_____	_____	_____	_____	___/__	___/__
Anemia	_____	_____	_____	_____	_____	___/__	___/__
Kidney Disease	_____	_____	_____	_____	_____	___/__	___/__
Bowel Disease	_____	_____	_____	_____	_____	___/__	___/__
Ulcer	_____	_____	_____	_____	_____	___/__	___/__
Tuberculosis	_____	_____	_____	_____	_____	___/__	___/__
Osteoporosis	_____	_____	_____	_____	_____	___/__	___/__
Thyroid disease	_____	_____	_____	_____	_____	___/__	___/__
Age if living	_____	_____	_____	_____	_____	___/__	___/__

What is your nationality/ethnicity?_____ Any known genetic risks _____

Your Health History

Childhood Illnesses: Scarlet fever Y N Diphtheria Y N Rheumatic fever Y N
Mono Y N Mumps Y N Measles Y N German measles Y N

Immunizations: Polio Y N Pertussis Y N
Varicella Y N Tetanus shot Y N Diphtheria Y N
HPV Y N Measles/Mumps/Rubella Y N Other _____

Any history of negative reactions to vaccination Y N_____

Hospitalizations and Surgeries
_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

X-Rays and Special Studies: X-rays, CAT scans, EKGs or other studies you have had:
_____
_____

Allergies: Medications/drugs _____
Environmentals _____
Any Food sensitivities or allergies _____

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
MAO inhibitors	Y N	Appetite suppressants	Y N	Diuretics	Y N
Stimulants	Y N	ADHD medications	Y N	Steroids	Y N

Please list **all** prescription, OTC meds, vitamins & supplements you are taking & the dose?

1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4)_____ 9)_____
5)_____ 10_____

Typical Daily Food Intake

Breakfast: _____
_____
Lunch: _____
Dinner: _____
_____
Snacks_____
Beverages _____

DIGESTION

Do you ever experience the following: Gas/bloating? Y N Frequency_____
Bowel movements/day_____ Constipation? Y N Diarrhea Y N
Irritable bowel Y N Bowel Disease Y N Ulcers Y N Heartburn Y N
Food, mucus or blood in your stool Y N Abdominal pain Y N
Frequent nausea and/or vomiting Y N Hemorrhoids Y N
Liver disease Y N Gall bladder disease Y N # Antibiotics/year_____

UTERINE MENSES BLADDER

Age of last menses? _____
Length of cycle? _____ days
Duration of menses? _____ days
Painful menses? Y N
Heavy or excessive flow? Y N
PMS? Y N
If yes, what are your symptoms?
_____
_____
Endometriosis? Y N
Ovarian cysts? Y N
Difficulty conceiving? Y N
Cervical Dysplasia? Y N
Sexual difficulties? Y N
Any difficulty with urination? Y N
Frequent urinary infections Y N
Low libido Y N

Are cycles regular? Y N
Bleeding between cycles? Y N
Pain during intercourse? Y N
Clotting? Y N
Discharge? Y N
Sexually active Y N
Birth control? Y N Type:_____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Menopausal symptoms? Y N
Last PAP_____Abnormal PAP Y N
Chlamydia or other STD Y N
Lose urine/ incontinence Y N
Urinary frequency Y N
Yeast infections Y N

Breast (circle): Pain Lumps Fibrocystic Lumpectomy Premenstrual tenderness Cancer
Last Mammogram:_____ Family history of breast/ovarian cancer Y N _____

PROSTATE AND MALE URINARY HEALTH

Do you experience difficult urination Y N
Painful urination Y N
Forked stream Y N
Waking at night to urinate Y N #/night_____
Venereal disease Y N
Sexually active Y N

Difficulty starting stream Y N
Prostate disease Y N
Testicular pain Y N
Hernias Y N
Low libido Y N
Sexual difficulties Y N
Erectile Dysfunction Y N

DAILY LIFESTYLE HABITS

Do you exercise regularly? Y N What form(s) & how often? _____
_____

Present Height _____Weight _____ lbs.
Maximum Weight _____ Date_____

Weight 1 year ago _____lbs.
Desired weight _____lbs.

When during the day is your energy the best _____ worst _____

Diet and lifestyle habits continued

Average 6-8 hrs. sleep?	Y	N	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/day _____		
Any major traumas?	Y	N	Read?	Y	N
Use recreational drugs?	Y	N	how many hours/day _____		
Treated for drug dependence?	Y	N	Alcoholic drinks/ week_____		
Do you eat three meals a day?	Y	N	History of drinking alcohol	Y	N
Do you eat out often?	Y	N	Treated for alcoholism?	Y	N
Do you go on diets often?	Y	N	Use tobacco presently	Y	N
Coffee cups/day_____			History of smoking	Y	N
Black or green tea cups/day_____			how many years _____		
Soda/cola cups/day_____			how many packs per day_____		

Any Artificial sweeteners in your diet?_____#/day_____

Do you have a religious/spiritual practice? Y N If yes, what?_____

Main interests and hobbies _____

_____

How does your condition(s) affect you?_____

_____

_____

What do you think is happening & why?_____

_____

_____

What do you feel needs to happen for you to get better? What is the most important part

of your healing process? _____

_____

_____

What do you enjoy most in your life?_____

_____

_____

Are you happy? What would you do to improve your life?_____

_____

_____

Which of the following would you prefer to be included in your health plan?

Dietary recommendations_____ Stress management _____ Exercise _____

Vitamins/Minerals_____ Other nutrients_____ Herbs _____ Homeopathy_____

Hydrotherapy _____ Bodywork _____ Counseling _____ Other _____