Wellness Lane,LLC

Health Inventory

This information is confidential and will only be released with your signed consent.

Name_____ Today's date_____

Address_____ Birthdate_____

County

_____ Age____Sex___Height_____Weight____

City State Zip

Phone: Work_____Cell_____ Legal status: S M C D Sep W

Home_____Email_____

Emergency Contact: Name_____ Living situation:_____

Phone#_____Relationship_____ Education completed:

If under 18,parent name/address_____ Elem___HS____Coll____Voc____Prof_____

_____

Referred by:_____ Occupation:_____

Address:_____ Retired: □ Yes □ No

Family Physician/Primary Care Provider: _____ Social security number:_____

_____Phone:_____

Address:_____ Medicare number:_____

Family History

□*Check if family history is unknown.*

	Age/DOB	State of Health; If dead cause of death		**Children**	**Age/DOB**	**Health status**
Mother						
Father						
Siblings						

Yes		Relationship
□	alcohol/drug problem	_____
□	allergy/asthma	_____
□	anemia	_____
□	arteriosclerosis	_____
□	arthritis	_____
□	binge eating/anorexia/bulimia	_____
□	bleeding problems	_____
□	cancer	_____
□	diabetes	_____
□	gonorrhea	_____
□	epilepsy/seizure	_____
□	heart disease	_____
□	skin disease	_____

Yes		Relationship
□	high blood pressure	_____
□	high cholesterol/fat	_____
□	kidney disease	_____
□	liver disease	_____
□	mental illness	_____
□	obesity	_____
□	stroke	_____
□	suicide	_____
□	thyroid disease	_____
□	tuberculosis	_____
□	ulcer	_____
□	syphilis	_____
□	other	_____

please go to next page

PAST HISTORY OF ILLNESS and MEDICAL PROBLEMS

Surgery: List all surgery and approximate dates

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Other Hospitalizations and dates

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Broken bones and/or traumatic injuries
Include all car accidents or concussions

_____ _____
_____ _____
_____ _____
_____ _____

Major complaints and duration
Example: High Blood Pressure 10 yrs

_____ _____
_____ _____
_____ _____
_____ _____

PAST HISTORY

YES		WHEN	YES		WHEN	YES		WHEN
☐	Acne	_____	☐	Epilepsy	_____	☐	Neurologic Problem	_____
☐	AIDS	_____	☐	Epstein Barr	_____	☐	Nightmares, frequent	_____
☐	Alcohol/Drug problems	_____	☐	Fibrocystic breasts	_____	☐	Overweight 20#	_____
☐	Allergies	_____	☐	Fibroids	_____	☐	Pelvic infection	_____
☐	Almagams/silver fillings	_____	☐	Gallbladder problems	_____	☐	Peptic ulcer	_____
☐	Anemia	_____	☐	Glasses/contacts	_____	☐	Periodontal disease	_____
☐	Antibiotics more than once a year	_____	☐	Glaucoma	_____	☐	Phlebitis	_____
			☐	Gonorrhea	_____	☐	Pneumonia	_____
☐	Anxiety	_____	☐	Gout	_____	☐	Premenstrual tension	_____
☐	Arteriosclerosis	_____	☐	Hay fever	_____	☐	Prostate problem	_____
☐	Arthritis	_____	☐	Hearing problem	_____	☐	Psychotherapy	_____
☐	Asthma	_____	☐	Heart attack	_____	☐	Reactions to vaccinations	_____
☐	Back pain/strain	_____	☐	Heart failure	_____			
☐	Binge eating	_____	☐	Heart problem	_____	☐	Rheumatic fever	_____
☐	Bladder infections	_____	☐	Hemorrhoids	_____	☐	Root canal	_____
☐	Blood clots	_____	☐	Hepatitis	_____	☐	Scarlet fever	_____
☐	Breast fed	_____	☐	Herpes	_____	☐	Sexually transmitted disease	_____
☐	Breast lump	_____	☐	Hiatal Hernia	_____			
☐	Bronchitis	_____	☐	High Blood Pressure	_____	☐	Sinusitis	_____
☐	Bulimia(self-induced vomiting)	_____	☐	High cholesterol/ triglycerides	_____	☐	Skin problems	_____
						☐	Sleep disorder	_____
☐	Cancer	_____	☐	Histoplasmosis	_____	☐	Stroke	_____
☐	Cataract	_____	☐	Hives	_____	☐	Suicide attempt	_____
☐	Chemical sensitivity	_____	☐	Hypoglycemia	_____	☐	Syphilis	_____
☐	Chicken pox	_____	☐	Infectious mono.	_____	☐	Taken steroid (cortisone/prednisone)	_____
☐	Chronic fatigue	_____	☐	Insomnia	_____			
☐	Coccidiomycosis	_____	☐	Kidney infection	_____	☐	Thyroid problems	_____
☐	Colds, frequent	_____	☐	Kidney stones	_____	☐	Tonsillitis	_____
☐	Colitis	_____	☐	Kidney problem	_____	☐	Tooth problems	_____
☐	Congenital defect	_____	☐	Liver disease	_____	☐	Tuberculosis	_____
☐	Counseling	_____	☐	Measles	_____	☐	Urine problems	_____
☐	Depression	_____	☐	Menstrual problem	_____	☐	Vaginitis	_____
☐	Diabetes	_____	☐	Mental illness	_____	☐	Vision problem	_____
☐	Ear infection	_____	☐	Migraine	_____	☐	Other problems	_____
☐	Eczema	_____	☐	Mumps	_____	_____		
☐	Endometriosis	_____	☐	Nervous condition	_____	_____		

PERSONAL HISTORY

Current medications
(list all prescription and non prescription)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Vitamin and mineral substances
(type and dosage)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies

I am allergic to the following medications:

_____
_____
_____
_____
_____
_____

If you have other known allergies to foods,chemicals or inhalants(i.e. pollens, animals,etc) Please list below:

_____
_____
_____
_____
_____

Lifestyle I

List your favorite food or cravings

_____
_____
_____
_____

I usually eat □ white bread □commercial wheat bread □ whole grain bread

I usually eat □ fresh □frozen □canned vegetables

I usually eat my vegetables □ raw □steamed □ boiled □ sautéed

I usually eat □ fresh □ frozen □ canned fruits.

I eat beef or pork □ at least once a day □5 times a wk □ less than three times a week □ never

I usually prepare my meat and fish □ pan fried □deep fried □ baked □ broiled □bar b qued

I eat refined sugar. □ yes □ no

My salt use is □ none added □ light □moderate □heavy

I drink □ city □ well □ spring □ distilled □ filtered water. _____ounces/day

I participate in an exercise program. □ yes □ no

I exercise on a regular basis. □ yes □ no

I often eat seconds. □ yes □ no

To control my weight, I have used: □fasting longer than 1 day
□diet pills □ self induced vomiting □ laxatives
□enemas □diuretics(water pills) □ health/diet
□ exercise-□ regular, □extreme. □ other_____

I am now or have been a smoker. □ yes □ no
How many years have you smoked?_____
When did you quit?_____
What do you smoke now?_____
How much?_____

I estimate my use of:
coffee:_____cups/day decaf:_____cups/day
tea:_____cups/day soda:_____oz-cans/day

I use □ beer □ wine □ "hard" liquor

I consider myself a □non drinker □social drinker □ heavy drinker □alcoholic □recovering alcoholic

I use □ marijuana □ other drugs _____

I need counseling or medical care to help me control my use of: □ alcohol □ tobacco □food □drugs

I would like nutritional counseling. □ yes □ no

I think this is enough exercise. □ yes □ no

I sleep well. □yes □no

I worry about □ money □job □ family life
□relationships □other_____

I find my work □too demanding □ boring □ satisfactory
□ very satisfactory □ excellent

My sex life is satisfactory. □ yes □ no

I do the following for relaxation/recreation:

Activity	Frequency

I am currently seeing a psychotherapist or other mental health professional. □ yes □ no

I am currently seeing a chiropractor, osteopath or other physical therapy person. □ yes □ no

I have been in the military. □ yes □no

I have been a victim of: □ physical □sexual
□ emotional abuse

In my life, I am safe: Emotionally □ yes □ no
Sexually □ yes □no Physically □ yes □no
Home □ yes □ no Work □ yes □ no
If not safe at do you have a safe place to go? □ Yes □No
Would you like some assistance? □ yes □no

I have been arrested. □ yes □ no

My spiritual life is satisfactory..□ yes □ no

I am currently involved in a spiritual program. □ yes □ no

My last physical exam was _____.

Life Changes

In the past 12 months, what changes have occurred in your:

1. Personal life

_____
_____
_____
_____

2. Family life

_____
_____
_____
_____

3. Social Life

_____
_____
_____
_____

4. Work Life

_____
_____
_____
_____

5. Sex Life

_____
_____
_____
_____

Review of Systems

Answer "yes" if you have had these symptoms in the last 6 months.

- ☐ Chronic fatigue
- ☐ Mood swings
- ☐ Chronic depression
- ☐ Trembling episodes
- ☐ Light-headedness
- ☐ Food-craving
- ☐ Frequent infection
- ☐ Night sweats
- ☐ Swollen glands
- ☐ Skin rashes
- ☐ Chills/ fever
- ☐ Change in skin or nails
- ☐ Change in wart or mole
- ☐ Abnormal bleeding/bruising
- ☐ Unusual hair loss/growth
- ☐ Change in hair loss/growth
- ☐ Irritability
- ☐ Restlessness
- ☐ Headaches
- ☐ Dizziness
- ☐ Balance problem
- ☐ Head injury
- ☐ Seizure/convulsion
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Fainting
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of any vision
- ☐ Halos around lights
- ☐ Excessive tearing/itching
- ☐ Eye pain
- ☐ Dark circles under eyes

Date of last eye exam_____

- ☐ Loss of hearing
- ☐ Ringing or bussing in ears
- ☐ Sinus trouble
- ☐ Nosebleed
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Change in voice
- ☐ Dental problem
- ☐ Dry mouth
- ☐ Excessive salivation
- ☐ Bleeding gums
- ☐ Mouth breather
- ☐ Chronic cough
- ☐ Bloody/yellow sputum
- ☐ Shortness of breath
- ☐ with exertion
- ☐ at night
- ☐ Bronchitis
- ☐ Chest pain with breathing
- ☐ High Blood Pressure
- ☐ Chest pain or pressure
- ☐ at rest
- ☐ with exertion
- ☐ with stress
- ☐ with eating
- ☐ down left arm or back
- ☐ accompanied by nausea, sweating, anxiety
- ☐ Irregular heartbeat
- ☐ Skipped beats
- ☐ Palpitations
- ☐ Fast heart beat
- ☐ Heart murmur
- ☐ Swelling feet/legs
- ☐ Cold hands/feet
- ☐ Leg cramps at night
- ☐ Pain or fatigue in legs with exercise
- ☐ Burning feet
- ☐ Sore legs/feet
- ☐ Color change legs/arms
- ☐ Pain/discomfort when eating
- ☐ Bad teeth
- ☐ Belching
- ☐ Coating on tongue
- ☐ Pain relieved by eating
- ☐ Nausea/vomiting
- ☐ Trouble with fried foods
- ☐ Bloating of the abdomen
- ☐ Bowel gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Clay colored stool
- ☐ Mucous in stool
- ☐ Hemorrhoids
- ☐ Rectal bleeding
- ☐ Abdominal pain
- ☐ Change in diet
- ☐ Pain/burning urination
- ☐ Frequent urination
- ☐ Urination at night
- ☐ Blood in urine
- ☐ Foul odor to urine
- ☐ Low back pain
- ☐ Loss of control/urine

MEN

- ☐ Enlarged prostate
- ☐ Decreased urine stream
- ☐ Unable to interrupt stream
- ☐ Dribbling after urination
- ☐ Pus or drainage from penis
- ☐ Genital swelling/rash
- ☐ Problem with sexual function

WOMEN

Last menstrual period _____
Age began menstruation_____
Age at menopause_____
Number of pregnancies_____
Number of live births_____
Number of abortions/miscarriages_____

- ☐ Complications of pregnancy
- ☐ Used birth control pills
- ☐ Used IUD

type:_____

Usual length of cycle:_____
Usual length of period bleeding:_____

- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Itching
- ☐ Self breast exam
- ☐ Lump in breast
- ☐ Would you like to learn self exam?
- ☐ Self vaginal exam
- ☐ Problem with sexual function
- ☐ Abnormal PAP smear
- ☐ Infertility

Date of last pap smear_____

Please continue to next page.

YES

- ☐ Muscle pain:
  Where:_____
- ☐ Muscle weakness:
  Where:_____
- ☐ Joint pain:
  Where:

YES

- ☐ Joint pain aggravated by motion
- ☐ Joint pain relieved by motion
- ☐ Swollen joints
- ☐ Stiff joints

How do you feel when you wake up in the morning?

In what position do you prefer to sleep?

Do you sleep through the night?
How do you fall asleep?
Do you need to get up to used the bathroom at night? What time?

Lifestyle:

How often do you ordinarily eat (anything) during a 24 hour period?

Foods:

List foods you crave:
List foods you would never eat/dislike:

Please list a typical day of food, beverage etc and include approximate serving size and timing of intake :

Breakfast:

Lunch:

Supper:

Snacks:

Are you pleased with your eating habits?
What would you change? **Would you like nutritional testing?**

****Exercise:**

How do you exercise?

How often in a wk would you exercise and for how long?

Do you perspire with exercise? Where do you notice the perspiration?

Are you satisfied with your level of exercise? Would you like more information?

Life Story

Please list in chronological order major events –personal, family social, work, emotional, physical, sexual, spiritual that have impacted your life:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please add anything that you want to be known, that has not been covered? Perhaps indicate what is/are the most important concern(s) for you.

Thank you! *This will be reviewed at our initial visit-with the goal of improving YOUR health and sense of wellness!*