

# 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 \_\_\_\_\_

Legal status: S M C D Sep W

Phone: Work \_\_\_\_\_ Cell \_\_\_\_\_  
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**
- alcohol/drug problem \_\_\_\_\_
- allergy/asthma \_\_\_\_\_
- anemia \_\_\_\_\_
- arteriosclerosis \_\_\_\_\_
- arthritis \_\_\_\_\_
- binge eating/anorexia/bulimia \_\_\_\_\_
- bleeding problems \_\_\_\_\_
- cancer \_\_\_\_\_
- diabetes \_\_\_\_\_
- gonorrhea \_\_\_\_\_
- epilepsy/seizure \_\_\_\_\_
- heart disease \_\_\_\_\_
- skin disease \_\_\_\_\_
- Relationship**

- Yes**
- high blood pressure \_\_\_\_\_
- high cholesterol/fat \_\_\_\_\_
- kidney disease \_\_\_\_\_
- liver disease \_\_\_\_\_
- mental illness \_\_\_\_\_
- obesity \_\_\_\_\_
- stroke \_\_\_\_\_
- suicide \_\_\_\_\_
- thyroid disease \_\_\_\_\_
- tuberculosis \_\_\_\_\_
- ulcer \_\_\_\_\_
- syphilis \_\_\_\_\_
- other \_\_\_\_\_
- Relationship**

## 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
<input type="checkbox"/> Acne	_____	<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Neurologic Problem	_____
<input type="checkbox"/> AIDS	_____	<input type="checkbox"/> Epstein Barr	_____	<input type="checkbox"/> Nightmares, frequent	_____
<input type="checkbox"/> Alcohol/Drug problems	_____	<input type="checkbox"/> Fibrocystic breasts	_____	<input type="checkbox"/> Overweight 20#	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Fibroids	_____	<input type="checkbox"/> Pelvic infection	_____
<input type="checkbox"/> Almagams/silver fillings	_____	<input type="checkbox"/> Gallbladder problems	_____	<input type="checkbox"/> Peptic ulcer	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Glasses/contacts	_____	<input type="checkbox"/> Periodontal disease	_____
<input type="checkbox"/> Antibiotics more than once a year	_____	<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Phlebitis	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Gonorrhea	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Arteriosclerosis	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Premenstrual tension	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Hay fever	_____	<input type="checkbox"/> Prostate problem	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Hearing problem	_____	<input type="checkbox"/> Psychotherapy	_____
<input type="checkbox"/> Back pain/strain	_____	<input type="checkbox"/> Heart attack	_____	<input type="checkbox"/> Reactions to vaccinations	_____
<input type="checkbox"/> Binge eating	_____	<input type="checkbox"/> Heart failure	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Bladder infections	_____	<input type="checkbox"/> Heart problem	_____	<input type="checkbox"/> Root canal	_____
<input type="checkbox"/> Blood clots	_____	<input type="checkbox"/> Hemorrhoids	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Breast fed	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Sexually transmitted disease	_____
<input type="checkbox"/> Breast lump	_____	<input type="checkbox"/> Herpes	_____	<input type="checkbox"/> Sinusitis	_____
<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> Hiatal Hernia	_____	<input type="checkbox"/> Skin problems	_____
<input type="checkbox"/> Bulimia(self-induced vomiting)	_____	<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Sleep disorder	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> High cholesterol/triglycerides	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Cataract	_____	<input type="checkbox"/> Histoplasmosis	_____	<input type="checkbox"/> Suicide attempt	_____
<input type="checkbox"/> Chemical sensitivity	_____	<input type="checkbox"/> Hives	_____	<input type="checkbox"/> Syphilis	_____
<input type="checkbox"/> Chicken pox	_____	<input type="checkbox"/> Hypoglycemia	_____	<input type="checkbox"/> Taken steroid (cortisone/prednisone)	_____
<input type="checkbox"/> Chronic fatigue	_____	<input type="checkbox"/> Infectious mono.	_____	<input type="checkbox"/> Thyroid problems	_____
<input type="checkbox"/> Coccidiomycosis	_____	<input type="checkbox"/> Insomnia	_____	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Colds, frequent	_____	<input type="checkbox"/> Kidney infection	_____	<input type="checkbox"/> Tooth problems	_____
<input type="checkbox"/> Colitis	_____	<input type="checkbox"/> Kidney stones	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Congenital defect	_____	<input type="checkbox"/> Kidney problem	_____	<input type="checkbox"/> Urine problems	_____
<input type="checkbox"/> Counseling	_____	<input type="checkbox"/> Liver disease	_____	<input type="checkbox"/> Vaginitis	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Vision problem	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Menstrual problem	_____	<input type="checkbox"/> Other problems	_____
<input type="checkbox"/> Ear infection	_____	<input type="checkbox"/> Mental illness	_____		
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Migraine	_____		
<input type="checkbox"/> Endometriosis	_____	<input type="checkbox"/> Mumps	_____		
		<input type="checkbox"/> 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 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 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 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 am currently seeing a psychotherapist or other mental health  
professional.  yes  no

I find my work  too demanding  boring  satisfactory  
 very satisfactory  excellent

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

My sex life is satisfactory.  yes  no

I have been in the military.  yes  no

I do the following for relaxation/recreation:

I have been a victim of:  physical  sexual  
 emotional abuse

<b>Activity</b>	<b>Frequency</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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!***