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: Elem HS College

If under 18,parent name/address_____

_____

Referred by:_____

Occupation:_____

Address:_____ Retired: ☐ Yes ☐ No

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

_____

Address:_____phone 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						

Relationship

☐ alcohol/drug problem _____

Relationship

☐ high blood pressure_____

please go to next page to continue

- ☐ allergy/asthma _____
- ☐ anemia_____
- ☐ arteriosclerosis_____
- ☐ arthritis_____
- ☐ binge eating/anorexia/bulimia_____
- ☐ bleeding problems_____
- ☐ cancer_____
- ☐ diabetes_____
- ☐ gonorrhea _____
- ☐ epilepsy/seizure _____
- ☐ heart disease _____
- ☐ skin disease _____
- ☐ high cholesterol/fat_____
- ☐ kidney disease_____
- ☐ liver disease_____
- ☐ mentalillness_____
- ☐ obesity_____
- ☐ stroke_____
- ☐ suicide_____
- ☐ thyroiddisease_____
- ☐ tuberculosis_____
- ☐ ulcer_____
- ☐ syphilis_____
- ☐ other_____

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 *(circle all that apply please)*

	WHEN		WHEN		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 _____
- ☐ Bulimia(self-induced vomiting) _____
- ☐ Cancer _____
- ☐ Cataract _____
- ☐ Chemical sensitivity _____
- ☐ Chicken pox _____
- ☐ Chronic fatigue _____
- ☐ Coccidiomycosis _____
- ☐ Colds, frequent _____
- ☐ Colitis _____
- ☐ Congenital defect _____
- ☐ Counseling _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Ear infection _____
- ☐ Eczema _____
- ☐ Endometriosis _____
- ☐ High Blood Pressure _____
- ☐ High cholesterol/ triglycerides _____
- ☐ Histoplasmosis _____
- ☐ Hives _____
- ☐ Hypoglycemia _____
- ☐ Infectious mono. _____
- ☐ Insomnia _____
- ☐ Kidney infection _____
- ☐ Kidney stones _____
- ☐ Kidney problem _____
- ☐ Liver disease _____
- ☐ Measles _____
- ☐ Menstrual problem _____
- ☐ Mental illness _____
- ☐ Migraine _____
- ☐ Mumps _____
- ☐ Nervous condition _____
- ☐ Sinusitis _____
- ☐ Skin problems _____
- ☐ Sleep disorder _____
- ☐ Stroke _____
- ☐ Suicide attempt _____
- ☐ Syphilis _____
- ☐ Taken steroid (cortisone/prednisone) _____
- ☐ Thyroid problems _____
- ☐ Tonsillitis _____
- ☐ Tooth problems _____
- ☐ Tuberculosis _____
- ☐ Urine problems _____
- ☐ Vaginitis _____
- ☐ Vision problem _____
- ☐ Other problems _____

_____

_____

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:

_____
_____
_____
_____
_____

Continue please to next page.

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 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 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 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

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

Please circle 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
- □ Mouth breather
- □ Chronic cough
- □ Bloody/yellow sputum
- □ Shortness of breath
- □ with exertion
- □ at night
- □ Bronchitis
- □ Abdominal pain
- □ Change in diet
- □ Pain/burning urination
- □ Frequent urination
- □ Urination at night
- □ Blood in urine
- □ Foul odor to urine

- ☐ 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
- ☐ 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
- ☐ 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_____

My last physical exam was _____.

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

please go to next page

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?

please go to next page

Life Story

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

Please continue below for child's more specific history-

Name_____ Birth Date_____ Sex: M F

Child's Parent's Names
A:_____**B**:_____

Address: see above on page one.

Home Phone _____ Cell# _____
Work # _____ E-mail _____
Parent Occupation
A:_____**B**:_____
Education of Parent: **A**: HS C Grad Other_____ **B**: HS C Grad Other_____

Primary Physician _____phone_____

Other Health Providers Seen Regularly (including alternative/complementary providers)
Name _____ Specialty _____
_____ _____
_____ _____
_____
Referred By _____

******Health History – Child******

Please list your main concerns:
_____
_____
_____
_____

What diagnoses or explanations have been given to you about your child? _____
_____
_____
_____
_____

Was there any event or illness that you or others feel brought on your child's symptoms? _____
_____
_____
_____
_____

	Dob	Age	Health Problems
Mother	_____		_____
Father	_____		_____
Sibling	_____		_____
Sibling	_____		_____
Sibling	_____		_____
Sibling	_____		_____

Maternal GM _____ _____
Maternal GF _____ _____
Paternal GM _____ _____
Paternal GF _____ _____

Family History [Check if ☐ family history is unknown]

Problem	age	Who
Alcohol/Drug Problem		
Endocrine/Hormonal Imbalance		
Gastro intestinal Disease		
Allergy/Asthma		
High Blood Pressure		
Skin Disease		
Anemia		
High Cholesterol/Fat		
ADD/ADHD		
Arteriosclerosis		
Kidney Disease		
Anxiety		
Arthritis		
Liver Disease		
Depression		

Problem	age	Who
Binge Eating/Bulimia		
Mental Illness		
Bleeding Problem		
Obesity		
Cancer		
Diabetes		
Epilepsy/Seizure		
Heart Disease		
Suicide		
Thyroid Disease		
Tuberculosis		
Other...		

Past History Of Illness And Medical Problems

Surgery: List all surgery and approximate dates

_____
_____
_____
_____
_____
_____
_____

Other hospitalizations and dates

_____
_____
_____
_____
_____
_____
_____

Broken bones and other traumatic injuries (include all car accidents ,head injuries or concussions) and dates

_____
_____
_____
_____
_____

Emergency room visits (please include reason and dates)

_____
_____
_____
_____
_____
_____

please go to next page.

Please check any symptoms that apply below and if special comments include them below:

- ☐ abdominal pain-chronic
- ☐ acne cataract hay fever/allergies
- ☐ AIDS chemical sensitivity hearing problem migraine
- ☐ allergies
- ☐ amalgams/silver fillings
- ☐ anemia
- ☐ anorexia
- ☐ antibiotics more than once a year
- ☐ anxiety
- ☐ arthritis
- ☐ asthma
- ☐ attention problem
- ☐ back pain/strain
- ☐ bed wetting
- ☐ blood clots
- ☐ breast lump
- ☐ bronchitis
- ☐ bulimia (self induced vomiting)
- ☐ cancer endometriosis menstrual problem
- ☐ chicken pox
- ☐ cholesterol/triglycerides
- ☐ chronic diarrhea
- ☐ chronic fatigue
- ☐ colds,
- ☐ colic high
- ☐ colitis
- ☐ congenital defect
- ☐ constipation
- ☐ counseling
- ☐ croup
- ☐ depression
- ☐ diabetes
- ☐ dyslexia
- ☐ ear infection
- ☐ eczema
- ☐ frequent high blood pressure
- ☐ hepatitis
- ☐ herpes nervous condition
- ☐ hiatal hernia
- ☐ hives
- ☐ hyperactivity
- ☐ hypoglycemia
- ☐ insomnia
- ☐ jaundice
- ☐ kidney infection
- ☐ kidney problem
- ☐ kidney stones
- ☐ learning disability
- ☐ liver disease
- ☐ mental disease
- ☐ mononucleosis
- ☐ neurologic problem
- ☐ overweight (20lbs.)
- ☐ panic attacks
- ☐ pelvic infection
- ☐ peptic ulcer
- ☐ pneumonia
- ☐ premenstrual
- ☐ psychotherapy
- ☐ reactions to vaccinations
- ☐ reflux
- ☐ rheumatic fever
- ☐ root canal
- ☐ scarlet fever
- ☐ scoliosis
- ☐ seizures
- ☐ sexually transmitted disease
- ☐ sinusitis
- ☐ skin problem
- ☐ sleep disorder
- ☐ suicide attempt
- ☐ syphilis
- ☐ taken steroid (cortisone/prednisone)
- ☐ tension
- ☐ thrush
- ☐ thyroid problem
- ☐ tics
- ☐ tonsillitis
- ☐ tooth problems
- ☐ urine problem
- ☐ vaginitis
- ☐ vision problem
- ☐ warts
- ☐ whooping cough

Please bring a copy of any immunizations given.

Please record any immunization reactions:

_____
_____
_____
_____
_____
_____

Any other comments on the symptoms above please include here:

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