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: _____number:_____

_____Phone:_____

Address:_____

PRIMARY CONCERNS:

1:_____

2:_____

3:_____

4:_____

MAJOR HEALTH ISSUES/INJURIES/HOSPITALIZATIONS:

_____

_____

Please continue to next Page

Medications/Supplements:

_____
_____
_____
_____
_____
_____
_____

Allergies:_____(No Allergies _)

_____
_____
_____
_____
_____
_____

Other Comments:

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	Yes	Relationship
☐	alcohol/drug problem _____	☐	high blood pressure_____
☐	allergy/asthma _____	☐	high cholesterol/fat_____
☐	anemia_____	☐	kidney disease_____
☐	arteriosclerosis_____	☐	liver disease_____
☐	arthritis_____	☐	mental illness_____
☐	binge eating/anorexia/bulimia_____	☐	obesity_____
☐	bleeding problems_____	☐	stroke_____
☐	cancer_____	☐	suicide_____
☐	diabetes_____	☐	thyroid disease_____
☐	gonorrhea _____	☐	tuberculosis_____
☐	epilepsy/seizure _____	☐	ulcer_____
☐	heart disease _____	☐	syphilis_____
☐	skin disease _____	☐	other_____

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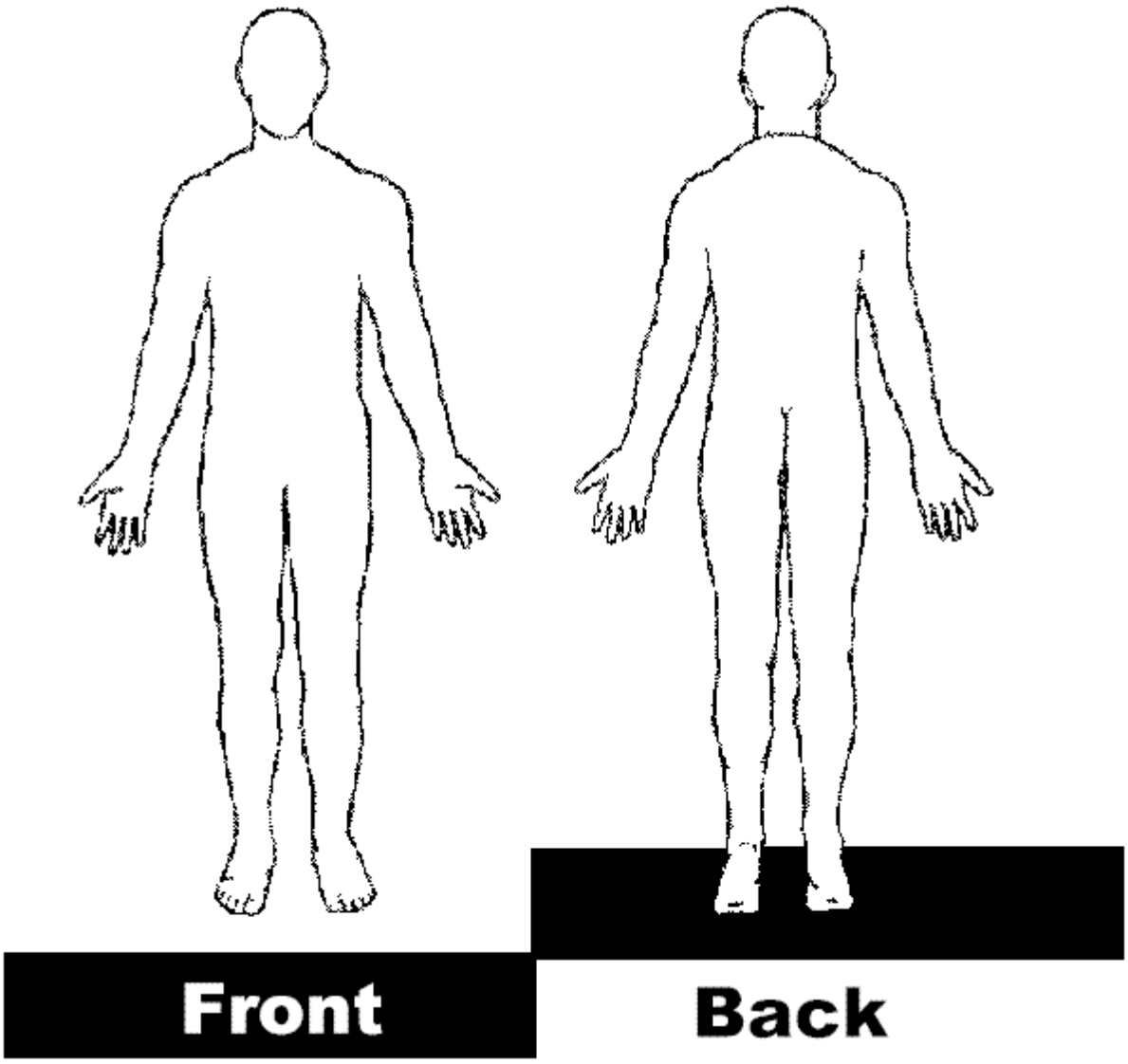

CIRCLE ANY TROUBLE SPOTS LABEL
PAIN OR NUMBNESS

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

Any other changes you have noticed? Please comment on back.

HOW MUCH WATER DO YOU DRINK A DAY_____Please- Plan to drink at least 32 oz in 2-3 hours before FSM visits + after.