WHOLESOME HEALING (512.535.8632)

Patient Intake Form

Full name		Sex ☐ F ☐ M	Date	
Date of Birth	Age	Occupation		
Main phone #		Other phone #		
E-mail address		Allow e-mail contact by WH ☐ Yes ☐ No		
Address:		City	State	Zip
Emergency contact name & phone		Marital status	# of children	
Family physician		Chiropractor		
How did you find out about our clinic?				

Main problem(s):_____

When did the problem begin?_____

What diagnosis, if any, have you received for this problem?_____

What kind of treatments have you tried?_____

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other		

Surgeries (types & dates): _____Hospitalization (reason & dates):_____

Significant trauma (auto accidents, sport injuries, etc): _____

Allergies (drugs, chemicals, foods, environmental): _____

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

_____

_____

Habits Do you smoke? ☐ Yes ☐ No What?_____How many per day? _____Since when?_____

Please describe any use of drugs for non-medical purposes: _____

Do you exercise regularly? ☐ Yes ☐ No Please describe your exercise program:_____

_____

Are you or have you been on a restricted diet? What kind and why? _____

_____

Please describe your average daily diet including beverages (Please be as specific as possible):

Morning _____

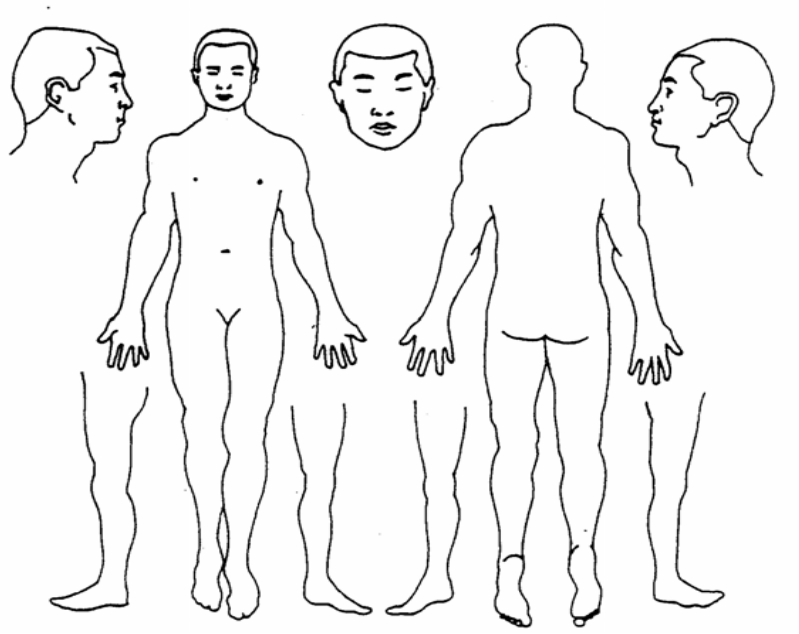
Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas.

Sharp/ Stabbing = XXXX	Numbness = NNNNN	Burning = BBBBB
Shooting = <<<<<	Dull/Aching = DDDDD	Cramps = CCCCC



Pain severity scale.

Please place a mark on the line that corresponds to your **current** pain

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

Please place a mark on the line that corresponds to your **average** pain

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

What brought the pain on?_____

What makes the pain better?_____ What makes it worse?_____

How often does the pain exist?_____And for how long?_____

Any prior injuries to the area of pain?_____

Have you seen another healthcare practitioner for the pain/condition?☐ Yes ☐ No If yes, who?_____

Check all that apply
Past: in the past 3 months
Current: Now and a week ago

ENERGY AND IMMUNITY

Past	Current	Condition
☐	☐	Fatigue
☐	☐	Catch cold easily
☐	☐	Fevers
☐	☐	Chills
☐	☐	Sweat easily
☐	☐	Night sweats
☐	☐	General weakness
☐	☐	Cravings
☐	☐	Chronic infection
☐	☐	Cold hands/feet
☐	☐	Peculiar tastes
☐	☐	Strong thirst [Cold or Hot drinks]
☐	☐	Sudden energy drop

SLEEP

Past	Current	Condition
☐	☐	Trouble falling asleep
☐	☐	Trouble staying asleep
☐	☐	Nightmares
☐	☐	Tired upon waking
☐	☐	Excessive dreaming

What hour do you go to sleep?_____
What hour do you wake up?_____

SKIN & HAIR

Past	Current	Condition
☐	☐	Rashes
☐	☐	Acne
☐	☐	Ulcerations
☐	☐	Dry skin/scalp
☐	☐	Bleed or bruise easily
☐	☐	Itching
☐	☐	Loss of hair
☐	☐	Other:_____

HEAD & NECK

Past	Current	Condition
☐	☐	Dizziness/Vertigo
☐	☐	Headache/Migraine
☐	☐	Other: _____

EARS

Past	Current	Condition
☐	☐	Infections
☐	☐	Earaches
☐	☐	Ringing
☐	☐	Decreased hearing
☐	☐	Other: _____

EYES

Past	Current	Condition
☐	☐	Blurred vision
☐	☐	Vision changes
☐	☐	Poor night vision
☐	☐	Spots
☐	☐	Cataracts
☐	☐	Eye strain
☐	☐	Eye pain
☐	☐	Glasses/contacts
☐	☐	Other:_____

NOSE, THROAT, MOUTH

Past	Current	Condition
☐	☐	Sinus problems
☐	☐	Sore throat
☐	☐	Grinding teeth
☐	☐	Difficulty swallowing
☐	☐	Sores on lips/tongue
☐	☐	Teeth problems
☐	☐	Other:_____

CARDIOVASCULAR

Past	Current	Condition
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	High cholesterol
☐	☐	Palpitations
☐	☐	Chest pain
☐	☐	Irregular heart beat
☐	☐	Rapid heart beat
☐	☐	Fainting
☐	☐	Difficulty breathing
☐	☐	Varicose veins
☐	☐	Other: _____

RESPIRATORY

Past	Current	Condition
☐	☐	Asthma/Wheezing
☐	☐	Allergies
☐	☐	Cough
☐	☐	Short of breath
☐	☐	Bronchitis
☐	☐	Pneumonia
☐	☐	Other: _____

GASTRO-INTESTINAL

Past	Current	Condition
☐	☐	Poor appetite
☐	☐	Excessive appetite
☐	☐	Nausea/Vomiting
☐	☐	Diarrhea
☐	☐	Belching
☐	☐	Bad breath
☐	☐	Bloating
☐	☐	Gas
☐	☐	Heartburn
☐	☐	Hemorrhoids
☐	☐	Constipation
☐	☐	Abdominal pain/cramps
☐	☐	Gallbladder problems

Bowel movements:
Frequency _____
Color _____
Odor _____
Texture/Form: ☐ Well-formed
☐ Hard
☐ Loose
☐ Watery
Feels complete? ☐ Yes ☐ No

GENITO-URINARY

Past	Current	Condition
☐	☐	Kidney stones
☐	☐	Painful / Burning urination
☐	☐	Frequent urination
☐	☐	Urgency to urinate
☐	☐	Unable to hold urine
☐	☐	Retention of urine
☐	☐	Dribbling
☐	☐	Profuse urination
☐	☐	Urinary tract infection
☐	☐	Genital itching
☐	☐	Genital rashes
☐	☐	Other: _____

NEUROLOGICAL

Past	Current	Condition
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Numbness / tingling of the limbs
☐	☐	Loss of balance
☐	☐	Poor memory
☐	☐	Poor concentration
☐	☐	Paralysis
☐	☐	Lack of coordination
☐	☐	Other: _____

PSYCHOLOGICAL

Past	Current	Condition
☐	☐	Sadness
☐	☐	Nervousness
☐	☐	Fear
☐	☐	Anxiety/Panic attacks
☐	☐	Frequent worrying
☐	☐	Irritability
☐	☐	Bad temper
☐	☐	Mood swings
☐	☐	Mania
☐	☐	Depression

MUSCULOSKELETAL

Past	Current	Condition
☐	☐	Joint disorders
☐	☐	Muscle weakness
☐	☐	Muscle spasm/ twitching/ cramps
☐	☐	Muscle soreness/ pain
☐	☐	Swelling of hands/feet
☐	☐	Spinal curvature
☐	☐	Hernia
☐	☐	Other:_____

FOR MEN ONLY

Past	Current	Condition
☐	☐	Prostatitis
☐	☐	Benign prostatic hyperplasia
☐	☐	Erectile dysfunction
☐	☐	Testicular pain
☐	☐	Frequent seminal emission
☐	☐	Nocturnal emissions
☐	☐	Painful / swollen testicles
☐	☐	Low sex drive
☐	☐	Low sperm count
☐	☐	Poor sperm motility
☐	☐	Fertility problems
☐	☐	Other: _____

FOR WOMEN ONLY

Is your menstrual cycle regular?

☐ Yes ☐ No

Length of cycle?____

Length of menstrual period: _____

First date of last period: _____

Age of first period: _____

Do you practice birth control?

☐ Yes ☐ No

If Yes, what type and for how long?

_____

Are you pregnant now? ☐Yes ☐No

Do you have the following menstrual related signs and symptoms?

☐ Abdominal cramps
☐ Lower back pain
☐ Acne
☐ Breast distension
☐ Nausea
☐ Water retention
☐ Mood swings
☐ Irritability
☐ Food cravings
☐ Migraines
☐ Changes in bowel movement
☐ Clots
☐ Spotting between periods
☐ Other: _____

Check all that apply:

☐ Vaginal itching
☐ Vaginal dryness
☐ Pain during intercourse
☐ Abnormal vaginal discharge
☐ Fibroids
☐ Ovarian cysts
☐ Breast lumps
☐ Fertility problems
☐ Hot flashes
☐ Low sex drive
☐ Abnormal pap smear
☐ Other: _____

Indicate number of occurrences:
Pregnancies: _____
Live Births: _____
Miscarriages: _____
Abortions: _____
Premature births: _____
C-section: _____
Difficult delivery: _____

I have completed this form correctly to the best of my knowledge.

Signature: ☐ Adult Patient ☐ Parent or Guardian ☐ Spouse