PERSONAL INFORMATION

Please provide the following information and answer the questions below.

Note: *all information provided is protected as confidential information.*

Name _____ Date of Birth: _____ (Last) (First)
(Middle Initial)

Gender Identification: *How do you prefer to identify?* _____ *What are your preferred pronouns?* _____

Address: _____
(Number and Street) (City) (State) (Zip)

Home Phone: ( ) *May we leave a message?* ☐ Yes ☐ No
Mobile (Other): ( ) *May we leave a message?* ☐ Yes ☐ No
May we text you? ☐ Yes ☐ No
Email _____ *May we leave a message?* ☐ Yes ☐ No
* *Email correspondences are not considered confidential communications.*

Name of Parent / Guardian (*if younger than 18 years of age*):
_____
(Last) (First) (Middle Initial)

Emergency Contact
_____
(Last) (First) (Middle Initial)
Relationship to You _____

Relationship Status:
☐ Single ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Partner/Spouse: _____

Name and Age of Any Children
_____

Nearest Relative _____ Phone _____

How Did You Hear About My Practice? _____
Referred By _____

Personal Wellness Goals

On the Continuum Below, Indicate with a Check Mark Your Current State of Well-Being?

Excellent _____ Poor

What are Your Current Health and Wellness Goals?

1. Physical health:

2. Mental - emotional health:

3. Spiritual health:

4. Relationships:

5. Community:

6. Career / Work:

7. Creativity / Passions / Recreations / Hobbies:

8. Personal development:

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How will you Know When you have Achieved Your Goals? What will Your Life Look Like? What will Be Different?

What is Your Life Purpose? Do You Have a Personal Mission Statement for Your Life? If So, What Is It?

Where Would You Like to see Your Life / Yourself / Your Health Six Months from Now?

Where Would You Like to See Your Life / Yourself / Your Health One Year from Now?

What, if Anything, Keeps you from Being Your Most Authentic, Vital Self? What Might be Limiting You, Holding You Back or Preventing You from Your Authenticity and Vitality?

What Do You Love and Celebrate about Yourself? What Do You Appreciate about Your Life?

What is Missing from Your Life?

What are Your Creative Outlets?

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Have There Ever Been Any Life Experiences / Situations Which Did, or Continue To, Affect You Deeply?

Do You Have Any Opinions or Ideas Regarding What Has Caused Your Present Health Conditions?

How Would You Describe Your Current Stress Level, and What Do You Do to Relax?

Is there Any Other Information You Think is Important or that You Would Wish to Share?

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Healthcare

Current Primary Care Provider _____

Last Seen _____ Last Complete Screening _____

For What _____

_____

Have You Had, or Do You Continue to Partake in the Following Towards Healing or Wellness? If so, Please List When and Any Comments You Wish to Make:

Yes	No	
☐	☐	Acupuncture
☐	☐	Biofeedback/ EEG Neurofeedback
☐	☐	Bodywork/Massage
☐	☐	Chiropractic
☐	☐	Exercise
☐	☐	Herbal / Botanical Medicine (which ones?)
☐	☐	Homeopathic Medicine (which ones?)
☐	☐	Meditation
☐	☐	Movement Therapy
☐	☐	Nutritional Supplements / Dietary Changes
☐	☐	Osteopathy/Cranio-Sacral Therapy
☐	☐	Physical Therapy
☐	☐	Psychotherapy / Counseling
☐	☐	Yoga
☐	☐	Other (s) _____

List Other Health Care Practitioners You Currently Consult:

Name_____When Consulted_____

For What? _____Treatment _____

_____

How Long have You Seen this Practitioner? _____ How Often? _____

Results _____

Name_____When Consulted_____

For What? _____Treatment _____

_____

How Long have You Seen this Practitioner? _____ How Often? _____

Results _____

List Any Prior Surgeries, Hospitalizations, and Major Injuries and Dates
Type/When/Doctor/Outcome

List any current or past allergies you have

List your current medications, who prescribed each, current dosage, and how often you take them, the benefits of taking them, and any side effects. Please include:

- Prescription medications
- Over the counter medications
- Vitamins
  Herbal supplements (East Asian and Western)
- Homeopathic Remedies

Medication/Supplements Dosage Frequency Benefits Side Effects

List of any medications that you don't tolerate well or have had a bad reaction to in the past

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Do you have any of the following concerns with your medications/supplements? (Circle all that apply.)
Costs too much
Run out often
Do not think I need it
Take differently than prescribed
Problems with side effects. Explain: _____

Please List the Ages and Health Concerns Of All Living Relatives. If Deceased, Please List at What Age They Died And, If Known, The Cause:

Mother _____
Father _____
Brother(s)/Sister(s) _____

Grandparents _____

Quality of Life

In general, would you say your health is? Circle: *Excellent* *Very Good* *Good* *Fair* *Poor*

During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

Accomplished less than you would like? Circle:
All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*

Were limited in the kind of work or other activities? Circle:
All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:

Have you felt calm and peaceful? Circle:
All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*

Did you have a lot of energy? Circle:
All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*

Have you felt downhearted and depressed? Circle:
All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (life visiting friends, relatives, etc.)? Circle:
All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*

Emotional Health

How often do you feel stress at home (feeling irritable, filled with anxiety, or have sleep problems as a result of conditions at home)?
Never *Some periods* *Several periods* *Permanent*

How often do you feel stress at work (feeling irritable, filled with anxiety, or have sleep problems as a result of conditions at work)?
Never *Some periods* *Several periods* *Permanent*

How would you describe your financial stress?
Little or none *Moderate* *High/severe* *None of the time*

Have you had any of the major traumatic life events within the past year: marital separation or divorce, loss of job or retirement, loss of crop or business failure, death or major illness of a close family member, death of a spouse, or other major stress?

__ *Yes* __ *No*

If Yes, Please Describe

_____

_____

_____

_____

Using the following scale, please circle the number representing how much you agree or disagree with the following statements:

0=Don't agree at all 3=Neither agree or disagree 6=Strongly agree

a. At home, I feel I have control over what happens in most situations	0	1	2	3	4	5	6
b. I feel that what happens in my life is often in my control	0	1	2	3	4	5	6
c. Over the next 5±10 years I expect to have many more positive than negative experiences:	0	1	2	3	4	5	6
d. I often have the feeling that I am being treated unfairly:	0	1	2	3	4	5	6
e. In the past 10 years my life has been full of changes without my knowing what will happen next:	0	1	2	3	4	5	6
f. I gave up trying to make big improvements or changes in my life a long time ago:	0	1	2	3	4	5	6
g. Keeping healthy depends on things that I can do:	0	1	2	3	4	5	6
h. There are certain things I can do for myself to reduce the risk of a heart attack:	0	1	2	3	4	5	6
i. There are certain things I can do for myself to reduce the risk of getting cancer:	0	1	2	3	4	5	6

Have you felt sad, depressed or "blue" for two weeks or more in a row over the past 12 months?

Yes No

If Yes, have you:

Lost interest in things?	Yes	No
Felt tired or low on energy?	Yes	No
Gained or lost weight?	Yes	No
Had trouble falling asleep?	Yes	No
Had trouble concentrating?	Yes	No
Thought of death?	Yes	No
Felt worthless?	Yes	No

Please rate how often you have been bothered by any of the following problems over the last 2 weeks using the following scale:

0=Not at All 1=Several Day 2=More than half the days 3=Nearly every day DK=Don't know

a. Little interest or pleasure in doing things.	0	1	2	3	DK
b. Feeling down, depressed, or hopeless.	0	1	2	3	DK
c. Trouble falling or staying asleep OR sleeping too much.	0	1	2	3	DK
d. Feeling tired or having little energy.	0	1	2	3	DK

e. Poor appetite OR overeating	0	1	2	3	DK
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0	1	2	3	DK
g. Trouble concentrating on things, such as reading a newspaper or watching television.	0	1	2	3	DK
h. Moving or speaking so slowly that other people could have noticed OR—the opposite—being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3	DK

Work / School History

Describe Your Current Work / School Situation (Where, What, Number of Hours)

How Would You Rate / Describe Your Stress Level at Work / School?

Do You Enjoy Your Work / School? Are You Fulfilled at Work?
If Yes, How Does it Fulfill You? If No, For What Purpose do You Stay at this Job?

What Would You Rather Be Doing with Your Life? What Prevents You

Describe Your Physical Work / School Situation: Seated / Standing / Work Bench / Desk / Counter / Other?
Lifting / Bending / Stooping / Twisting / Walking / Other

Types of Shoe Worn _____
Type of Chair _____

Physical Activity

Do You Like Your Body? If No, In What Ways are You Dissatisfied With It and Why?

Are You Physically Active / Do You Exercise? If So, What Type(s)? _____

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What is Your Typical Physical Activity Schedule?

Monday _____ Thursday _____
Tuesday _____ Friday _____
Wednesday _____ Saturday _____
Thursday _____ Sunday _____

For What Reason(s) Do You Exercise?

Are You Happy with Your Level of Physical Activity, and If No, Where Would You Like it to Be?

Do You Enjoy Physical Activity? Do You Enjoy Exercise?

What Do You Like Most about Exercising?

What Do You Like Least about Exercising?

Have You Ever Discontinued Strenuous Exercise/Sports and Why?

What Fears, If Any, Do You Have About Physical Activity? _____

What Would Be Your Ideal Setting in which to Exercise? Why?

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Sleep History

Number of Hours of Sleep per Night During Weekdays ____ Do You Wake Refreshed ☐ Y ☐ N
Number of Hours of Sleep per Night During Weekends ____ Do You Wake Refreshed ☐ Y ☐ N
Ideal Number of Hours You Would Like to Sleep/Night? ___Do You Fall Asleep During Day? ☐ Y ☐ N

Do You Have Difficulty Falling Asleep at Night? ☐ Y ☐ N How Long Does it Take to Fall Asleep _____
Do You Wake in the Middle of the Night? ☐ Y ☐ N
Can You Return to Sleep/How Long? _____
What Wakes You? _____ Are You a Heavy or Light Sleeper? _____
Do You Have Nightmares (Frequency/Type)? _____
Please List Any Recurring Dreams or Themes to Your Dreams, Either in the Past or Currently (Frequency or Type)? _____

_____

_____

Do You Sleep with Windows Open or Closed, Why? _____
Do You Talk/Grind Teeth/Drool/Sleepwalk/ Have Leg Cramps or Restless Legs at Night? _____

_____

What is Your Preferred Position in Which to Sleep, and Why? _____
When You Sleep, Do you Ever Uncover Any Body Parts, and Which? _____
What is Your Best Time of Day (Physically, Emotionally or Mentally)? _____
What is Your Worst Time of Day? _____

Diet & Nutrition

Please Circle Appropriate Answer and Complete

Consume Alcohol?	☐ Y ☐ N	What/How Often/Socially or Alone _____
Smoke	☐ Y ☐ N.	How Long/How Many / Day _____
Past History	☐ Y ☐ N	When and How Long _____
Caffeine Intake	☐ Y ☐ N	In What Form/How Often/Craving _____
Sugar Intake	☐ Y ☐ N	Form/How Often/Craving _____
Use Saccharine or NutraSweet	☐ Y ☐ N	What Form/How Much per Day _____
Fast Food Intake	☐ Y ☐ N	How Often/Where _____
Carbonated Drinks?	☐ Y ☐ N	How Often/Which Ones _____
Drink Water?	☐ Y ☐ N	How Many Glasses per Day/Sources _____
Eat Fried Foods?	☐ Y ☐ N	How Often/Where/What _____
Eat Margarine?	☐ Y ☐ N	How Much per Day _____
Eat Meat	☐ Y ☐ N	How Often per Week _____
Eat Poultry	☐ Y ☐ N	How Often per Week _____
Eat Fish	☐ Y ☐ N	How Often per Week _____
Dietary Restrictions?	☐ Y ☐ N	What/How Long _____

Do You Have Any Consistent Food Cravings, Foods You Just Need to Eat or Those That You Find You Eat on a Regular Basis (If not a specific food, any particular flavors or tastes)? _____

What Foods Do You Dislike or Avoid Because You Do Not Like the Taste? _____

Are There Any Foods That You React to on Any Level? _____

What is Your Thirst Like? Do You Sip or Gulp? And What Temperature of Beverages Do You Prefer, and Why? _____

What Does Food Mean to You? _____

Are You Satisfied with Your Diet? __ Y __ N In What Way Would You Like Your Diet to Change?

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How is Your Current Diet Serving You? (What is the Pay-off For Your Current Way of Eating? Our Behaviors Always Serve Us Somehow.)

What Would it Require/What Would You Need to Change Your Diet?

In Your Opinion, What Would a Health Diet Look Like?

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