Wellness Intake Questions

Date:________Name:____________________________Signature:_____________________________

Sex: Male ☐ Female ☐ Marital Status: Married ☐ Single ☐ Widowed ☐

Age: _________ Height: __________ Weight: _______ Past: _______ Current_______

Occupation____

Date of birth___________________ Time and Place of Birth:_______________________________

Address: ____State: _________

Zip: ___________

Phone: _________________________Email: ____

Why are you interested in Wellness Counseling?
____

Please list your objectives and perception of what you may achieve from this counseling.____

____

____

____

Please list your top 3 complaints and describe in terms of: Type, Onset, Duration, Progression, what you have tried and who you have consulted for each.

1.____

2. ____

3. ____

Is your sleep disturbed by the symptoms?
Not at all ☐ Some what ☐ Moderately ☐ Severely ☐ Very Severely ☐

Please scale the degree of bodily pain or discomfort:
Not at all ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Are you currently under the care of a family physician or other medical professional?
No ☐ Yes, please
explain____

What is their opinion about your health?
Easily cured ☐ Difficult to cure ☐ Incurable ☐ Did not say ☐

Have you undergone any investigations for blood, urine, stools, x-ray, ultra sound, MRI, etc.? If yes, please explain in detail.

____
____
____
____

Do you have any past medical history? If yes, please specify the age of occurrence, duration, and its treatment.

____
____
____
____
____
____

Is there a family history of health problems? If yes, please specify.

Concern	Father	Mother	Brothers	Sisters	Spouse	Child	Other
Age (If Living)							
Age (At Death)							
Cause of death							
Anemia							

Cancer							
Diabetes							
Epilepsy							
Glaucoma							
Heart Disease							
High blood pressure							
Hay Fever							
Hives							
Kidney Disease							
Mental Disease							
Rheumatoid Arthritis							
Tuberculosis							
Syphilis							
Stroke							
Others							

Health as a child: Good ☐ Fair ☐ Poor ☐

Childhood Illnesses: ____

Body Systems Appraisal

Check items below, which apply on a recurrent basis at the present time of within the past year.

1. **Head, Ears, Eyes, Nose, and Throat**

☐ Migraine Headaches
☐ Headaches
☐ Dizziness
☐ Fainting Spells
☐ Earaches, Discharges
☐ Hearing Loss
☐ Ringing in the Ears
☐ Pain/Soreness in the Eyes
☐ Deteriorating Vision
☐ Cataracts
☐ Glaucoma
☐ Thinning/Loss of Hair
☐ Nose Colds
☐ Nasal/Sinus Congestion
☐ Nasal Discharges
☐ Hay Fever-type Allergies
☐ Nose Bleeding
☐ Gums Bleeding
☐ Gums Receding
☐ Numerous Dental Cavities
☐ Wear Dentures
☐ Oral Infections
☐ Mouth/Lip ulcers or lesions

2. **Respiratory System**

☐ Shortness of Breath with exertion
☐ Wheezing
☐ Painful Breathing
☐ Persistent cough
☐ Frequent Chest Colds
☐ Lung Congestion
☐ Coughing up Blood
☐ Coughing up mucous

3. **Cardiovascular and Lymph Systems**

☐ Tension/pain behind breastbone
☐ Leg Pain upon Exercise

Possibly radiating down left arm, especially after physical exertion
- ☐ Fast Heart Beat
- ☐ Irregular Heart Beat
- ☐ Hands/feet become numb easily
- ☐ Painful hands/feet due to coldness
- ☐ Varicose Veins
- ☐ Lymph Node Swelling

4. **Muscular-Skeletal System**

- ☐ Swelling/pain in joints
- ☐ Limitation on Joint movement
- ☐ Muscle weakness/atrophy
- ☐ Muscle/Bone deformities
- ☐ Muscle/Bone pains in back/neck
- ☐ Muscle/Bone pains elsewhere

5. **Neurologic System**

- ☐ Loss of taste, smell, or touch
- ☐ Tingling Sensation
- ☐ Tremors in limbs
- ☐ Muscle/limb coordination problems
- ☐ Difficulty in Remembering
- ☐ Difficulty in thinking clearly

6. **Urinary System**

- ☐ Loss of control of urination
- ☐ Painful urination
- ☐ Urine retention/dribbling
- ☐ Frequent daytime urination
- ☐ Frequent nighttime urination
- ☐ Blood un urine
- ☐ Pain in kidney/groin area
- ☐ Frequent kidney/bladder infections
- ☐ Urine is odorous
- ☐ Color or urine is light yellow
- ☐ Color or urine is medium yellow
- ☐ Color of urine is dark yellow

7. **Reproductive System**

(Male)

- ☐ Prostate swollen, painful
- ☐ Abnormal discharges from penis
- ☐ Pain on intercourse
- ☐ Excessive sex drive
- ☐ Impotence Problems
- ☐ Genital ulcers or lesions
- ☐ Reduced or minimal sex drive

(Female)

- ☐ Premenstrual Tension
- ☐ Menstruation too frequent
- ☐ Depression at menstruation
- ☐ Swelling, Pain, Lumps in breasts
- ☐ Abnormal vaginal discharges
- ☐ Genital ulcers or lesions
- ☐ Reduced or minimal sex drive
- ☐ Menstruation Prolonged
- ☐ Menses scanty or missed
- ☐ Menopausal hot flashes
- ☐ Pain in ovaries
- ☐ Frequent vaginal infections
- ☐ Pain on intercourse
- ☐ Excessive sex drive

8. **Gastrointestinal System**

- ☐ Heaviness/bloating after eating
- ☐ Frequent Indigestion
- ☐ Pain/burning in stomach area
- ☐ Gallbladder discomfort
- ☐ Diarrhea
- ☐ Less than 2 bowel movements daily
- ☐ Hemorrhoids
- ☐ Excessive intestinal gas
- ☐ Blood in stools
- ☐ Stools are odorous

Stools are Clay color ☐ Brown ☐

Stools are: Loose ☐ Hard ☐

- ☐ Difficult/Painful bowel movements

Stools: Float ☐ Sink ☐

Describe your bowel movements:

- ☐ Once every 2-3 days
- ☐ Once daily
- ☐ 2-3 times per day
- ☐ First thing in the AM
- ☐ Late in daytime
- ☐ Immediately after meal
- ☐ Immediately after dinner
- ☐ Need laxative daily
- ☐ Other_____________

Bowel Nature: Soft ☐ Medium ☐ Hard ☐

Bowel movement associated with:
Pain ☐ Gas ☐ Blood ☐ Mucous ☐ Foul smell ☐ Other______________

Energy Level

Rate your basic energy level on a scale of 1-100% (Optimum) __________

And/or: My Energy level is: Very High ☐ High ☐ Moderate ☐ Low☐ Very Low ☐

Overall Health

Rate your overall health on a scale of 1-100% (Optimum) __________

1. Sleep

How many hours do you sleep at night? __________

How many hours of daytime sleep do you get with naps? __________

Is your sleep position on your: Side ☐ Back ☐ Stomach ☐

Is your sleep usually: Sound ☐ Interrupted ☐

If your sleep is interrupted please describe time of arousal and ease of falling back to sleep:____
____
____

____
____
____

Do you normally wake up feeling refreshed in the morning? Yes ☐ No ☐

2. Body Weight

How much did you weigh at 21? (Answer in pounds) __________

How much more ☐ or less ☐ do you weigh now than at age 21? __________

How much have you gained ☐ or loss ☐ in the past year? __________

Do you presently feel that you are: Overweight ☐ Underweight ☐

Are you satisfied with your current body tone and shape? Yes ☐ No ☐

3. Drug Allergies

List below the names of drugs to which you have known allergic reactions.

____
____
____
____
____
____

4. Pharmaceutical Medications

List below the pharmaceutical drugs (perscription and non-prescription) which you take regularly, explain what condition they are taken for, specify the amount taken on a daily basis and who prescribed or suggested them

____
____
____
____

5. Herbal Preparations and Supplements

List below any herbs, herbal preparations and supplements which you take regularly, explain what condition they are taken for, specify the amount taken on a daily basis and who prescribed or suggested them

____
____
____
____
____
____

6. Exercise and Wellness Practices

Do you practice any type of meditation? Please describe type and frequency

____
____
____
____

Do you practice any Yoga techniques? Please describe type and frequency

____
____
____
____

Describe the type, amount, and frequency of vigorous physical activity you engage in on a daily regular basis.

____
____
____
____

Is vigorous physical activity difficult for you? If yes, please explain. Yes ☐ No ☐

7. Sunlight Exposure

On a regular daily basis, do you spend at least 20 minutes outdoors during the daylight hours without wearing glasses or sunglasses? Yes ☐ No ☐

Do you regularly sunbathe between the hours of 11:00AM and 4:00PM during the warmer months of the year? Yes ☐ No ☐

8. Emotional/Mental Stress

What is your present state of mind and emotions? Good ☐ Fair ☐ Poor ☐

Do you often experience any of the following?

☐ Worry	☐ Depression	☐ Lack of energy	☐ Anxiety
☐ High stress	☐ Lack of memory	☐ Suicidal tendency	☐ Fear or panic
☐ Anger	☐ Loneliness	☐ Lightheadedness	☐ Irritation

Are you easily prone to becoming upset or irritable? Yes ☐ No ☐

Rate the amount of stress you are currently experiencing on a scale of 1-10 (highest)

____

If you are presently experiencing a great deal of stress, please explain what you feel is causing the stress.

____
____
____
____

9. Smoking

Do you regularly smoke at the present time? Yes ☐ No ☐

If yes, please explain the quantity of cigarettes, cigars, or pipe tobacco that you smoke on a daily basis.

____
____

If you do smoke, have you made any serious attempts to give up smoking? Yes ☐ No ☐

10. Alcohol

Do you drink alcoholic beverages more than once a week? Yes ☐ No ☐

If yes, please explain the type and amount of such beverages usually consumed and how often they are consumed.

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11. Recreational Drugs

Do you use recreational drugs with any sort of regularity? Yes ☐ No ☐

If yes, please explain the nature and frequency of the usage.

____

____

Diet Background

1. Appetite and Digestion

Rate the strength of your appetite on a scale of 1-100% __________

Rate the strength of your digestion on a scale of 1-100% __________

Do you experience indigestion frequently? Yes ☐ No ☐

If yes, please explain.

____

____

____

____

____

____

2. Diet Preferences and Changes

Have you made any major changes in your diet in the past ten years? Yes ☐ No ☐

If yes, please explain these changes.

Please describe your diet: Vegan, Macrobiotic, Vegetarian, "Flexatarian" or other

3. **Food Sensitivities:** Have you ever undergone specialized tests to determine your own food sensitivities or food allergies? Yes ☐ No ☐

If yes, please describe the test results and explain whether or not the test was helpful.

4. **Drinking Water**

Indicate the type of drinking water you most commonly use.

☐ City Water (fluoridated)
☐ Private well water
☐ Distilled water
☐ Reverse osmosis water
☐ City Water (Non-fluoridated)
☐ Bottled spring/well water
☐ Carbon filtered city water
☐ Other________________________

Do you eat the following food groups?

Food Groups	Daily	Weekly	Monthly	Never
Grains/cereals				

Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meat				
Seafood				
Sugar/honey				
Desserts				
Juices				
Caffeine beverages				

Please explain your typical food habit:

Breakfast:
____

Lunch: ____

Dinner:
____

Snacks:
____

Do you snack between meals? If yes, what snacks?
____

Do you eat your meals on time? Yes ☐ No ☐

Which is your main meal? Breakfast ☐ Lunch ☐ Dinner ☐

Rate your digestion: Good ☐ Fair ☐ Poor ☐

How much water do you drink per day?
None ☐ 1-2 Glasses ☐ 3-4 Glasses ☐ 5-6 Glasses ☐ 7+ Glasses ☐

What tastes do you like or crave? Salty ☐ Sweet ☐ Sour☐ Bitter ☐
Hot/spicy ☐ Starches ☐ Oily ☐

Are there any foods that create discomfort when you eat them? No ☐ Yes, please specify____

____

____

____

____

____

____

General Questions:

What kind of weather makes you feel uncomfortable? (Choose one)
Cold ☐ Hot ☐ Cool and damp ☐

How regular is your daily routine? (Do you go to bed early, eat your meals on time, exercise regularly?)
Very regular ☐ Somewhat regular ☐ Irregular ☐

Do you travel a lot? Yes ☐ No ☐

How are your family relationships? Excellent ☐ Good ☐ Fair ☐ Poor ☐

How is your social life? Excellent ☐ Good ☐ Fair ☐ Poor ☐

How is your career? Love it ☐ Like it ☐ Can stand it ☐Cannot stand it ☐

How purposeful is your life? Completely ☐Somewhat ☐ Neutral ☐ Not happy ☐

Rate your spiritual life: Fully satisfying ☐ Somewhat satisfying☐ Neutral ☐ Empty ☐

As a child, did you experience any abuse or trauma? None ☐ Verbal ☐Physical ☐ Sexual ☐ Emotional ☐ Other ☐

____

What do you consider some of your strengths?

____

____

What do you consider to be some of your weaknesses?

____

____

For women only:

Age menses began: _________________

Which of the following describes your menstruation? (You may choose more than one)

Regular ☐ Irregular ☐ Too frequent ☐ Absent ☐ Ceased due to menopause ☐

How many days does your menstrual cycle last?____

How is your menstrual flow?
Heavy ☐ Light ☐ Normal ☐ Abnormal vaginal discharges ☐

Associated Symptoms (before or during flow)
None ☐ Pain ☐ Fluid retention ☐ Migraine ☐ Depression ☐
Acne ☐ Tension ☐ Anger ☐ Frustration ☐ Loneliness ☐
Nightmares ☐ Suicidal tendency ☐ Other, please specify____________

Do you have any discharge outside of your menstrual period? Yes ☐ No ☐

Do you experience pain during intercourse? Yes ☐ No ☐

Do you have any sexual difficulties? No ☐ Yes, please explain_____________________________

Are you pregnant now? Yes ☐ No ☐ Don't know ☐

Do you take contraceptive pills or other devices? No ☐ Yes, please explain________________

Please state the number of previous pregnancies____

How many children do you have?____________ Children's ages____________________________

Do you self-exam your breasts regularly?

____

Do you experience any problems in your breasts?

____