



FAMILY WELLNESS CENTER

A Natural Approach to Wellness

100 Great Oaks Boulevard, Suite 106
Albany, New York 12203 • Phone: 518-464-3611

Confidential Patient History

Full Name: _____ Date: _____

Mailing Address: _____
(street) (city) (state) (zip)

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ Email: _____

Age: _____ Birth date: _____ Height: _____ Weight: _____

Marital Status: **M S W D** Spouse / Guardian Name: _____

Pregnant? **Yes No** # of children: _____ Occupation: _____

Type of Work You Do: _____

Person Responsible for account: _____

Name of Insurance Company: _____

How did you discover our office? _____

If a personal referral, whom may we thank for referring you? _____

I. HEALTH CONCERNS & PHYSICAL HISTORY

List concerns according to their severity	Severity 1= mild 10=extreme	Date Started	If you had the condition before, when?	% of time pain is present
1. _____	_____	_____	_____	_____ %
2. _____	_____	_____	_____	_____ %
3. _____	_____	_____	_____	_____ %

Who have you seen for these conditions (MD, Chiropractor, PT, Counselor etc.), what did they say they thought was wrong, what did they do, and did it help? What else have you done for these conditions, and in each case, did it help (ice, heat, rest, meditation, biofeedback, less alcohol/drugs, less destructive sports/activities, exercise, change diet, etc.)? Please attach additional sheet if necessary.

Do you have a family history of these or similar symptoms? **Yes No**

Please explain: _____

Circle the aspects of your life are interfered with by the health conditions (**work, school, sleep, daily routine, eating, walking, recreation/play, exercise, moods, relationships, other**)? _____

What activities aggravate your condition(s)? _____

Are you unable to do certain activities that you would like to do because of this condition? (I.e.: sports, walk, pick up grandchildren, etc.) If so, what? _____

List surgeries (including dental) and broken bones?

<u>Type</u>	<u>Date</u>	<u>Doctor (or Hospital if Don't Know Dr's Name)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had x-rays taken? **Y** **N** When: _____
For what reason: _____

Do you wear orthotics or heel lifts? **Y** **N** Starting When _____
Were they prescribed? **Y** **N**

Accidents/injuries/hospitalizations: auto, work, sports, etc. (incl. significant. childhood injuries):

<u>Type</u>	<u>Date</u>	<u>Hospitalized/EmergRm</u>		
1. _____	_____	Hosp	ER	No
2. _____	_____	Hosp	ER	No
3. _____	_____	Hosp	ER	No
4. _____	_____	Hosp	ER	No
5. _____	_____	Hosp	ER	No
6. _____	_____	Hosp	ER	No

For the hospitalizations and ER visits, what was done? _____

Exercise (Circle what applies):
I am **Sedentary, Mildly Active, Active, Extremely Athletic**

I do **aerobics, swimming, walking, power walking, walking with weights, running, weight lifting, aerobic weight training, yoga, biking, paddling, horseback riding, other** _____.

Circle **N** for any conditions you have **NOW** and **P** for ones in the **PAST**.

- | | | | | | |
|----------------------------------|-------------------------|-------------------------|--------------------------------|-----------------------|-------------------------|
| <u>N P</u> Vein Problems | <u>N P</u> Cancer | <u>N P</u> Sleep Apnea | <u>N P</u> Auto immune dx | <u>N P</u> Arthritis | <u>N P</u> Eczema |
| <u>N P</u> Heart Attack | <u>N P</u> Pneumonia | <u>N P</u> Ulcers | <u>N P</u> ↓Sense of Smell | <u>N P</u> Insomnia | <u>N P</u> Gout |
| <u>N P</u> Arteriosclerosis | <u>N P</u> Emphysema | <u>N P</u> Warts | <u>N P</u> Thyroid Problems | <u>N P</u> Fatigue | <u>N P</u> Neuritis |
| <u>N P</u> High Blood Pressure | <u>N P</u> Infections | <u>N P</u> Skin Problem | <u>N P</u> PMS | <u>N P</u> ↑Emotions | <u>N P</u> Ringing Ears |
| <u>N P</u> Heart Disease | <u>N P</u> Pleurisy | <u>N P</u> Diarrhea | <u>N P</u> Menstrual Cramps | <u>N P</u> Moodiness | <u>N P</u> Miscarriage |
| <u>N P</u> Stroke | <u>N P</u> Asthma | <u>N P</u> ↓Memory | <u>N P</u> Irregular Periods | <u>N P</u> ↓Emotions | <u>N P</u> Neck Pain |
| <u>N P</u> Anemia | <u>N P</u> Allergy | <u>N P</u> Swelling | <u>N P</u> Irritable Bowel Syn | <u>N P</u> Depression | <u>N P</u> Back Pain |
| <u>N P</u> COPD | <u>N P</u> Sinus Prob. | <u>N P</u> Numbness | <u>N P</u> Constipation | <u>N P</u> Nervous | <u>N P</u> Epilepsy |
| <u>N P</u> Gall Bladder Problems | <u>N P</u> Jaw Prob. | <u>N P</u> Tingling | <u>N P</u> Blood Sugar Prob. | <u>N P</u> Anxiety | <u>N P</u> Convulsions |
| <u>N P</u> Carpal Tunnel Syn. | <u>N P</u> Headaches | <u>N P</u> ADD/ADHD | <u>N P</u> Diabetes | <u>N P</u> Addictions | <u>N P</u> Nerve Probs. |
| <u>N P</u> Weight Problems | <u>N P</u> Fibromyalgia | <u>N P</u> Eye Problems | <u>N P</u> High Pain Tolerance | | |

N P Other - Please explain: _____

Circle all that apply:

During my mom's pregnancy: she had a fall/accident/injury, the pregnancy was difficult, C-section, forceps or suction, prolonged, breech, cord around the neck, natural, and other _____

II. CHEMICAL HISTORY

Current Pharmaceuticals: Please list **ALL** drugs (prescription and over-the-counter) you currently take or have taken in the past 6 months.

<u>Name</u>	<u>Frequency</u>	<u>For What</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List past medications taken for more than 2 cumulative months (incl. childhood.)

<u>Name</u>	<u>For What</u>
_____	_____
_____	_____
_____	_____

My mother was drinking alcohol, smoking, having caffeine, or taking any other drug immediately prior to or during her pregnancy with me? **Yes No**
 Her labor was chemically induced or altered w/ spinal anesthesia or some other drug(s)? **Yes No**
 I was fed **Breast Milk Only for** _____ **Formula Fed Only** **Nursed & Formula**

I am exposed to fumes, chemicals and smoke with my job or hobbies? **Past Current No**
 I am exposed to radiation, xray, altitude w/ my job or hobbies? **Past Current No**

Please grade the following according to the frequency per day, week or month.

Ex: 1/d, 2/w, 1/m...

- | | | | |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> Fried Food/Fast Food | <input type="checkbox"/> Diet Food | <input type="checkbox"/> Fasting | <input type="checkbox"/> Hydrogenated Fats |
| <input type="checkbox"/> Weight Control Diet | <input type="checkbox"/> Dairy | <input type="checkbox"/> Meat | <input type="checkbox"/> Sugary foods |
| <input type="checkbox"/> Vegetables/Fruits | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Water |
| <input type="checkbox"/> Skipping Meals | <input type="checkbox"/> Artificial Sweeteners | <input type="checkbox"/> Caffeine | |
| <input type="checkbox"/> Processed Foods (margarine & artificial colors/flavors) | | | <input type="checkbox"/> White foods (white bread, pasta, rice...) |

The type of diet I usually follow is classified as (vegetarian, macrobiotic, low fat, high protein, low calorie, etc.) _____

- Do you have poor eating habits? Yes No Occasionally
- Do you have trouble choosing or preparing healthy food? Yes No Occasionally
- Do you need or want to lose weight? Yes No
- Do you have emotional ties to food? Yes No Occasionally
- What is your energy level:
- | | | | |
|---------------------------------|-----|----------|------|
| In the morning when you wake up | Low | Moderate | High |
| In the afternoon | Low | Moderate | High |
| In the evening | Low | Moderate | High |

How many glasses of water do you consume a day? _____

How many hours of sleep do you get regularly? _____

How is your overall stress level on a day to day basis? Low Moderate High

If dietary changes were recommended would you be willing to make changes? **Yes No Maybe**

Are you interested in nutritional supplements to be healthier? **Yes No Maybe**

Would you like to know more about how the food you eat affects your overall health and well being? **Yes No Maybe**

Would you be interested in getting support in reaching your life goals at a pace that works for you? **Yes No**

III. EMOTIONAL HISTORY

My birth was: **Home Birthing Center Hospital Other** _____

I was incubated or isolated after birth? **Yes No**

My mother was under a lot of stress: **While Pregnant w/ me When I Was Age 1-8**

Please indicate the severity either past or current by **CIRCLING** the most appropriate.

Potential Spinal Stress/Tension Sources	PAST			CURRENT		
	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Childhood Stress	Mild	Moderate	Extreme			
School Stress	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Family Stress	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Personal Relationships	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Stress of Being Sick	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Work Stress	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Stress of Commuting	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Loss of Loved One	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Change in Lifestyle	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Change in Vocation	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc)	Mild	Moderate	Extreme	Mild	Moderate	Extreme

IV. RATE YOUR HEALTH

Please **CIRCLE** choices

My Physical Health is **improving** or **getting worse**?

My Physical Health is **Excellent Good Fair Poor** and is **Improving** or **Getting Worse**

My Mental Health (memory, ability to be rationalize, ability to think of alternate solutions, etc.) is **improving** or **getting worse**?

My Mental Health is **Excellent Good Fair Poor** and is **Improving** or **Getting Worse**

My Emotional Health (able to feel a full range of emotions without needing to suppress them and yet not being overwhelmed by them on a regular basis) is **improving** or **getting worse**?

My Emotional Health is **Excellent Good Fair Poor** and is **Improving** or **Getting Worse**

My Spiritual Health if applicable (being able to listen to your inner voice, awareness of your inner body rhythms, and the connectedness between yourself and all people and things) is **improving** or **getting worse**?

My Spiritual Health is **Excellent Good Fair Poor** and is **Improving** or **Getting Worse**

What are your hopes and needs to get from care in this office (w/ respect to physical, mental, emotional, and/or spiritual health, and quality of life? _____

Is there anything that has not yet been discussed that may help the doctor better understand you, your health and/or your needs? _____

Signature: _____

Date: _____