Richeson WELLNESS

Intake

Please take time to answer the questions as thoroughly and accurately as possible. The more we know, the better we can help. Put a ? in the box if you don't know the answer to a question, or N/A if it does not apply to you.

General

Name: _____ Today's Date: _____/_____/_____
First *Last*

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____
Number, Street *Apt # (optional)*

_____
City *State/Province* *Zip Code/Postal*

Preferred Phone Number: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

How did you hear about our office? _____

Emergency Contact: _____
Name *Phone Number*

Current Health

What are your top three health goals (ex. Lose weight, sleep better, more energy, better digestion, etc.)?

1. _____
2. _____
3. _____

What, if anything, have you done in the past to address these issues?

What is your main reason for seeking treatment at this time?

Did something trigger change in your health or symptoms?

Do you have any habits you would like to begin to change?

Please provide us with a list of current/ongoing health concerns, in order of most to least bothersome.

PROBLEM	DATE OF ONSET	SEVERITY/ FREQUENCY	TREATMENT APPROACH	SUCCESS

Quality of Life

How has your health condition affected your job, relationships, finances, family, or other activities?

What are you unable to do as a result of your health condition?

What do you wish you were able to do that you are unable to because of your health condition?

What do you think your health and life will be like 10 to 20 years from now if you do nothing about your current health situation?

Lifestyle History

Body Measurements:

Height (feet/inches)		Current Weight	
Usual Weight +/- 5lbs.		Desired Weight Range (+/- 5lbs.)	
Highest Adult Weight		Lowest Adult Weight	
Weight Fluctuations (>10 lbs.)		Body Fat %	

Smoking:

Currently Smoking: ☐ Yes ☐ No How many years? _____ Packs per day? ____ Attempts to quit? ___

Previous Smoking: ☐ Yes ☐ No How many years? _____ Packs per day? ____ Attempts to quit? ____

Alcohol Intake:

How many drinks do you have per week? (1 drink = 5 oz wine, 12 oz beer, 1.5 oz spirits)

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10

Do you notice a tolerance to alcohol? ☐ Yes ☐ No

Have you ever been unable to remember what you did during a drinking episode? ☐ Yes ☐ No

Do you get into arguments or physical fights when you have been drinking alcohol? ☐ Yes ☐ No

Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No

Other Substances:

Are you currently using any recreational drugs? ☐ Yes ☐ No

Have you ever used recreational drugs? ☐ Yes ☐ No

Psychosocial:

Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you like the work you do? ☐ Yes ☐ No

Have you ever experienced major losses in your life? ☐ Yes ☐ No

Do you spend the majority of your time and money to fulfill responsibilities? ☐ Yes ☐ No

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

Stress/Coping:

Are you currently in therapy? ☐ Yes ☐ No

Have you ever sought counseling? ☐ Yes ☐ No

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

Daily stressors: Rate on a scale 1-10, with 10 being the most stressful

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

What meditation or relaxation techniques, if any, do you regularly practice?

☐ None ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other

Hobbies and leisure activities: _____

Sleep/Rest:

What time do you go to bed? _____ What time do you wake up? _____

Average hours of sleep per night _____ Do you have trouble falling asleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No Do you struggle with insomnia? ☐ Yes ☐ No

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS (LAST 10 YEARS)

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplication & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever cause you unusual side effects or problems?	Yes No
Describe: _____	
Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?	Yes No
Have you had prolonged or regular use of Tylenol?	Yes No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)	Yes No
Frequent antibiotics > 3 times /year	Yes No
Long term antibiotics?	Yes No
Use of steroids (prednisone, nasal allergy inhalers) in the past	Yes. No
Use of oral contraceptives?	Yes No

Nutritional

Please check all the following that apply to your daily habits

	Erratic eating pattern		Love to eat
	Fast eater		Eat because I have to
	Late night eating		Have a negative relationship to food
	Dislike healthy food		Eat mostly organic foods
	Significant other or family members don't like healthy foods		Emotional eater (eat when sad, lonely, de-pressed, bored)
	Eat more than 50% meals away from home		Eat too much under stress
	Travel frequently		Eat too little under stress
	Non-availability of healthy foods		Don't care to cook
	Do not plan meals or menus		Eating in the middle of the night
	Reliance on convenience		Confused about nutrition advice
	Poor snack choices		Significant other or family members have special dietary needs or food preferences
	Time constraints		Eat too much

Please write out a full day of eating (including caffeine), with general timing of meals:

Do you currently follow a special diet or nutritional program? If so, please describe.

GI History

Have you ever traveled outside the U.S.? If so, when, and where? _____

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

Please check one of the following for each question-

How often do you have a bowel movement	__>3 a day __1-3 a day __4-6 a week __2-3 a week __1 or fewer a week
Soft and well formed	__>3 a day __1-3 a day __4-6 a week __2-3 a week 1 or fewer a week
Often floats	__>3 a day __1-3 a day __4-6 a week __2-3 a week 1 or fewer a week
Difficult to pass	__>3 a day _1-3 a day __4-6 a week __2-3 a week __1 or fewer a week
Diarrhea	__>3 a day __1-3 a day __4-6 a week __2-3 a week 1 or fewer a week
Thin, long or narrow	__>3 a day __1-3 a day __4-6 a week __2-3 a week 1 or fewer a week
Small and hard	_>3 a day __1-3 a day __4-6 a week __2-3 a week __1 or fewer a week
Loose but not watery	__>3 a day __1-3 a day __4-6 a week __2-3 a week 1 or fewer a week
Alternating between hard and loose/ watery	__>3 a day __1-3 a day __4-6 a week __2-3 a week 1 or fewer a week
COLOR	__Medium brown consistently
	__Very dark or black
	__Greenish color

COLOR CONT.	___Blood is visible
	___Varies a lot
	Dark brown consistently
	___Yellow, light brown
	___Greasy, shiny appearance
INTESTINAL GAS	Daily
	Occasionally
	Excessive
	Present with Pain
	Foul Smelling
	Little Odor

Medical History

Diseases/Diagnosis/Conditions

Check appropriate box and provide date of onset (mm/yyyy). Put an F if an immediate family member has the condition

Past	Ongoing	GASTROINTESTINAL
		Irritable Bowel Syndrome
		Inflammatory Bowel Disease
		Crohn's
		Ulcerative Colitis
		Gastritis or Peptic Ulcer Disease
		GERD(reflux)
		Celiac Disease
		Gallstones
		Other

Past	Ongoing	CARDIOVASCULAR
		Heart Attack
		Other Heart Disease
		Stroke
		Elevated Cholesterol
		Arrythmia
		Hypertension (high blood pressure)
		Celiac Disease (Rheumatic Fever)
		Mitral Valve Prolapse
		Other
Past	Ong	

Past	Ongoing	CANCER
		Lung Cancer
		Breast Cancer
		Colon Cancer
		Ovarian Cancer
		Prostate Cancer
		Skin Cancer
		Other

Past	Ongoing	GENITAL & URINARY SYSTEMS
		Kidney Stones
		Gout
		Interstitial Cystitis
		Frequent Urinary Tract Infections
		Frequent Yeast Infections
		Erectile Dysfunction or Sexual Dysfunction
		Other

Past	Ongoing	MUSCULOSKELETAL/PAIN
		Osteoarthritis
		Fibromyalgia

	oing	METABOLIC/ENDOCRINE			
					Chronic Pain
					Other
		Type 1 Diabetes	Past	Ongoing	INFLAMMATORY/AUTOIMMUNE
		Type 2 Diabetes			
		Hypoglycemia			
		Metabolic Syndrome			Chronic Fatigue Syndrome
		Insulin Resistance or Pre-Diabetes			Autoimmune System
		Hypothyroidism (low thyroid)			Rheumatoid Arthritis
		Hypothyroidism (overactive thyroid)			Lupus SLE
		Endocrine Problems			Immune Deficiency Disease
		Polycystic Ovarian Syndrome (PCOS)			Herpes-Genital
		Infertility			Severe Infectious Disease
		Weight Gain			Poor Immune Function
		Weight Loss			Food Allergies
		Frequent Weight Fluctuations			Environmental Allergies
		Bulimia			Multiple Chemical Sensitivities
		Anorexia			Latex Allergy
		Binge Eating Disorder			Hepatitis
		Night Eating Disorder			Other
		Eating Disorder (non-specific)			

Gynecological

Men Only

	Have you ever had a PSA done?				
	PSA Level:	0-2	2-4	4-10	>10
	Prostate Enlargement	Prostate Infection	Change in Libido	Impotence	
	Difficulty Obtaining an Erection		Difficulty Maintaining an Erection		
	Nocturia(urination at night)		How many times a night? _____		
	Urgency/Hesitancy/Change in Urinary System		Loss of urine control		

Women Only

PLEASE CHECK IF YOU ARE EXPERIENCING OR HAVE EXPERIENCED ANY OF THE FOLLOWING-

OBSTETRIC HISTORY (Check Box If Yes And Provide Number Of)

Pregnancies		Post Partum Depression	
Caesarean		Toxemia	
Vaginal Deliveries		Gestational Diabetes	
Miscarriage		Baby Over 8 pounds	
Abortion		Breast Feeding	
Living Children		for how long? _____	

MENSTRUAL HISTORY

Age at First Period		Menses Frequency		Length		Pain___Yes ___No	
Clotting		Has your period ever skipped for how long?					
Last Menstrual Period?							
Use of hormonal contraception such as?		Birth Control Pills		Patch		NuvaRing	
		How Long? _____					
Do you use contraception?		Condom		Diaphragm		IUD	Partner Vasectomy

WOMEN'S DISORDERS/ HORMONAL IMBALANCES

Do you experience breast tenderness, water retention, irritability or PMS symptoms in the second half of your cycle? Yes No

Please advise of any other symptoms that you feel are significant: _____

Fibrocystic Breasts	Endometriosis	Fibroids	Infertility
Painful Periods	Heavy Periods	PMS	
Last breast check? _____		Breast Biopsy/Date: _____	
Last PAP Test?		Normal	Abnormal
Last Bone Density? _____			
Results:	High	Low	Within Normal Range
Are You Menopause?		Age at Menopause? _____	

Hot Flashes	Mood Swings	Concentration/ Memory Problems	Joint Pains
Vaginal Dryness	Decreased Libido	Heavy Bleeding	Headaches
Weight Gain	Palpitations	Loss of Control of Urine	
Use of hormone replacement therapy?		How Long? _____	
What Type?	Estrogen	Progesterone	Ogen / Estrace
	Premarin	**Proverq**	Other: _____

Past	Ongoing	GENERAL	Past	Ongoing	HEAD	Past	Ongoing	SKIN
		Fever			Poor concentration			Cuts heal slowly
		Chills/Cold all over			Confusion			Bruise easily
		Aches/Pains			Headaches			Rashes
		General weakness			Concussion/Whiplash			Pigmentation
		Difficulty sweating			Mental sluggishness			Changing moles
		Excessive sweating			Forgetfulness			Calluses
		Swollen glands			Indecisive			Eczema
		Cold hands & feet			Face twitch			Psoriasis
		Fatigue			Poor Memory			Dryness/cracking skin
		Difficulty falling asleep			Hair loss			Oiliness
		Sleepwalker			**EYES**			Itching
		Nightmares						
		No dream recall			Feeling of sand in eyes			Acne
		Early waking			Double vision			Boils
		Daytime sleepiness			Blurred vision			Hives
		Distorted vision			Poor night vision			Fungus on nails
		EARS			See bright flashes			Peeling skin
					Halo around lights			Shingles
		Aches			Eye pains			Nails split
		Discharge/Conjunctivitis			Dark circles under eyes			White spots/lines on nails
		Pains			Strong light irritates			Crawling sensation
		Ringing			Cataracts			Burning on bottom of feet
		Deafness/Hearing loss			Floaters in eyes			Athletes foot
		Itching			Visual hallucinations			Cellulite

		Pressure			Conjunctivitis			Sensitive skin
		Hearing Aid			**NECK**			**THROAT**
		Frequent infections						
		Tubes in ears			Stiffness			Mucus
		Sensitive to loud noises			Swelling			Difficulty swallowing
		Hearing hallucinations			Neck glands swell			Frequent hoarseness
					Lumps			Tonsilitis
								Enlarged glands
								Constant throat clearing
Past	**Ongoing**	**NOSE/SINUSES**	**Past**	**Ongoing**	**CIRCULATION**	**Past**	**Ongoing**	**MOUTH**
		Stuffy			Swollen ankles			Coated tongue
		Bleeding			Sensitive to hot			Sore tongue
		Running/Discharge			Sensitive to cold			Dental problems
		Watery nose			Extremities cold or clammy			Bleeding gums
		Congested			Hands/feet go to sleep			Canker sores
		Infection			Numbness/tingling			TMJ
		Polyps			High blood pressure			Cracked lips
		Drainage			Chest pain			Chapped lips
		Sneezing spells			Dizziness upon standing			Fever blisters
		Post nasal drip			Fainting spells			Grinding teeth when sleeping
		No sense of smell			High cholesterol			Bad breath
		GASTROINTESTINAL			High triglycerides			Dry mouth
					Wheezing			**KIDNEY/URINARY TRACT**
		Peptic/duodenal ulcer			Irregular heartbeat			
		Poor appetite			Palpitations			Burning

		Excessive appetite			Low exercise tolerance			Frequent urination
		Gallstones			Frequent coughs			Blood in urine
		Nervous stomach			Breathing heavily			Nighttime urination
		Indigestion			Frequent sighing			Problem passing urine
		Heartburn			Shortness of breath			Kidney pain
		Acid reflux			Night sweats			Kidney stones
		Hiatal hernia			Varicose veins			Painful urination
		Nausea			Mitral valve prolapse			Bladder infections
		Vomiting			Murmurs			Kidney infections
		Abdominal pains			Skipped heartbeat			Bedwetting
		Gas			Heart enlargement			**JOINTS/TENDONS/ MUSCLES**
		Diarrhea			Heart pain			
		Constipation			Bronchitis/pneumonia			Muscle stiffness in morning
		Changes in bowels			Emphysema			Head injury
		Rectal bleeding			Croup			Muscle cramping
		Bloating			Frequent colds			Balance problems
		Belch frequently			Heavy/tight chest			Weak
		Anal itching			Prior heart attack			Pain wakes you
		Anal fissures						
Past	Ongoing	**WOMENS HISTORY**	Past	Ongoing	**MENS HISTORY**	Past	Ongoing	**EMOTIONAL**
		Fibrocystic breasts			Prostate enlargement			Convulsions
		Lumps in breast			Prostate infection			Dizziness
		Painful periods			Change in libido			Fainting spells
		Heavy periods			Infertility			Blackouts/amnesia
		Change in period			Lumps in testicles			Jittery

		Breast soreness before period			Genital pain			Startled by sudden noises
		Endometriosis			Hernia			Anxiety
		Non-period bleeding			Prostate cancer			Forgetful
		Breast soreness during period			Low sperm count			Feeling ‘lost’
		Vaginal dryness			Difficulty obtaining erection			Listless/groggy
		Vaginal discharge			Difficulty maintaining erection			Short attention span
		Partial/total hysterectomy			Nocturia			Unable to reason
		Hot flashes			Loss of bladder control			Worry needlessly
		Mood swings						Unusual tension
		Concentration/memory issues						Frustration
		Breast cancer						Emotional numbness
		Ovarian cysts						Cold sweats
		Pregnant						Profuse sweating
		Infertility						Depressed
		Decrease libido						Awaken by scary dreams
		Heavy bleeding						Irritable
		Join pains						Hostility or aggressive behavior
		Headaches						Fatigue
		Weight gain						Hyperactive
		Loss of bladder control						Restless leg syndrome
		Palpitations						Clumsy
		Frequent infections						Vision changes
		Tubes in ears						Inability to coordinate muscles
		Sensitive to loud noises						‘Workaholic’
		Hearing hallucinations						Daytime sleepiness
								Trouble staying asleep

									Trouble falling asleep
									Hallucinations

Readiness

Rate on a scale of: 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:	Very Willing				Unwilling
	5	4	3	2	1
Significantly modify your diet					
Take several nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (e.g. work demands, sleep habits)					
Practice relaxation techniques					
Engage in regular exercise					
Have periodic lab tests to assess progress					

Rate on a scale of 5 (very confident) to 1 (not confident at all)

	Very confident			Not confident	
	5	4	3	2	1
How confident are you of your ability to organize and follow through on the above health related activities?					
At the present time, how supportive do you think the people in your household will be to your implementing the above changes?					