Souldance Wellness Intake Form

2115 NE Wyatt Ct Suite 101 Bend OR 97702 236 NW Kingwood Ave Redmond OR

Contact Info:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (home): _____(cell):_____

E-mail: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

How did you hear about this clinic? _____

Demographics:

Age:_____ Date of Birth:_____ Gender: F M

Are you: Single____ Married___ Separated___ Divorced____ Widowed____ Relationship _____

Live With: Spouse___ Partner___ Relatives___ Friends___ Alone___ Parents___

Occupation:_____ Hours per wk:_____ Retired:_____

Employer:_____

Insurance name_____ ID number_____ Group number_____

Primary insured (if other than self)_____ primary insured DOB_____

Thank You For Your Time & Effort

Holistic health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Health History Questionnaire

Do you currently have a primary care doctor? Y N

Name: _____ Location: _____ Phone: _____

Are you currently under the care of any other physician/healthcare providers?

Name: _____ Location: _____ Phone: _____

Specialty/Reason for seeing:_____

Name: _____ Location: _____ Phone: _____

Specialty/Reason for seeing: _____

Name: _____ Location: _____ Phone: _____

Specialty/Reason for seeing: _____

What are your most important health problems? List in order of importance.

1.)_____Onset: _____

2.)_____Onset: _____

3.)_____Onset: _____

4.)_____Onset: _____

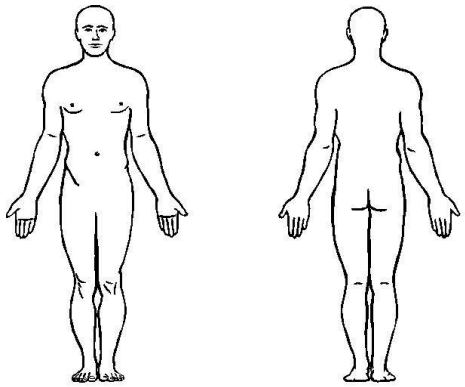
Souldance Wellness Intake Form

When was the last time you had excellent/optimal health? _____
How long do you think it will take for you to return to excellent health? _____

What three expectations do you have of me personally as your health care provider?

_____
_____
_____

Please mark the areas of pain
on the diagram to the right



Please describe your symptoms

Location:_____
Quality (aching, stabbing, etc) _____
What makes it better _____ worse?_____
Severity (0-10)_____
Things that have been tried to alleviate symptoms in the past _____
_____
_____
Constant/Intermittent?_____
Have symptoms been getting better, worse or the same since onset? _____
Was the symptom onset gradual or sudden? Explain. _____
_____
_____

How much do symptoms interfere with: (0= not at all, 10= completely interferes with the activity)

General activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Walking	0	1	2	3	4	5	6	7	8	9	10
Normal work (inc housework)	0	1	2	3	4	5	6	7	8	9	10
Relations with other people	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of life	0	1	2	3	4	5	6	7	8	9	10

General

Height _____ Weight _____ Maximal Weight _____When _____
Weight one year ago _____

Souldance Wellness Intake Form

Past Medical History please list any past or current medical conditions

_____
_____
_____
_____
_____

Hospitalization, Surgery or Imaging (x-rays, CT scans, MRI's, etc)

_____ year _____ _____ year _____
_____ year _____ _____ year _____
_____ year _____ _____ year _____
_____ year _____ _____ year _____

Allergies & Hypersensitivities

Drugs?_____
Foods?_____ Environmental or chemical?_____

Medications & Supplements

Please list any prescriptions & over the counter medications you take consistently. Attach additional sheet if needed.

Drug:_____ Dose:_____ How long?_____
Drug:_____ Dose:_____ How long?_____
Drug:_____ Dose:_____ How long?_____
Drug:_____ Dose:_____ How long?_____

Please list any **supplements** you are currently taking. Please include the brand name.

_____ Dose:_____ How long?_____
_____ Dose:_____ How long?_____
_____ Dose:_____ How long?_____
_____ Dose:_____ How long?_____

Diet

Do you follow a certain diet? Y N
If yes, please circle. Vegetarian Vegan Paleolithic Anti-inflammatory Gluten-free Dairy-free Other_____
What do you typically eat for each meal?
Breakfast:_____
Lunch:_____
Dinner:_____
How much water do you drink each day?_____
How much caffeine do you consume? _____ coffee soda tea other_____

Souldance Wellness Intake Form

Family History: Please indicate age if alive or age of death and any medical issues

Mother_____
Father_____
Brothers _____
Sisters_____
Children _____

Habits, Hobbies, and Lifestyle

Please rate your stress on a scale from 1 to 10 (10 = most) 0 1 2 3 4 5 6 7 8 9 10

Please rate your energy on a scale from 1 to 10 (10 = most) 0 1 2 3 4 5 6 7 8 9 10

Please answer Y = yes, N = no, or P = in the past
Do You Exercise? Y N P
What Type? _____
How Often? _____
How Many Hours? _____
Take regular vacations? Y N P Date of last vacation_____
Do you have a religious or spiritual practice? Y N P
Describe _____
Do you use any illegal substances? Y N P What/how often _____
Do you drink alcohol? Y N P What/how much/how often_____
Have you ever felt that you need to cut down on your drinking? Y N
Have you ever needed an "eye opener", a drink first thing in the morning to steady your nerves or get over a hangover? Y N
Have you ever felt guilty about how much you drink? Y N
Have you ever been annoyed with others for criticizing your drinking? Y N
Have you ever been treated for alcoholism Y N
Do you use tobacco Y N P
How much _____
If in past, how many years _____
Use recreational drugs Y N P Ever treated for drug dependence? Y N
What do you do for fun?_____
Any behaviors you feel are supporting your health? _____
_____
Any behaviors you feel are destructive to your health? _____
_____

Review of Systems:

Please Circle All That Apply

Y = Current issue N = never had P = Past problem

General
Fatigue Y N P
Fevers Y N P
Chills Y N P
Wake well rested Y N

Skin
Rashes Y N P
Itching Y N P
Other_____

Head
Headaches Y N P
Head Injury Y N P
Jaw issues Y N P
Other _____

Neck
Lumps Y N P
Swollen Glands Y N P
Pain or Stiffness Y N P
Other _____

Eyes
Eye Pain Y N P
Tearing Y N P
Dryness Y N P
Double Vision Y N P
Other _____

Ears
Impaired hearing Y N P
Ringing Y N P
Earaches Y N P
Dizziness Y N P
Other _____

Nose and Mouth
Frequent Colds Y N P
Sinus Problems Y N P
Cold sores Y N P
Other _____

Respiratory
Cough Y N P
Wheezing Y N P
Difficulty Breathing Y N P
Pain with Breathing Y N P
Shortness of Breath Y N P

Cardiovascular
Chest Pain Y N P
Murmurs Y N P
Swelling in ankles Y N P
Palpitations Y N P
Other _____

Gastrointestinal
Diarrhea Y N P
Constipation Y N P
Nausea Y N P
Vomiting Y N P
Bowel Movements
How frequent? ____
Is this a change Y N
Other _____

Urinary
Pain on Urination Y N P
Increased Frequency Y N
Urgency Y N P

Peripheral Vascular
Deep Leg Pain Y N P
Cold Hands & Feet Y N P
Other _____

Musculoskeletal
Joint Pain/Stiffness Y N P
Arthritis Y N P
Muscle Spasms Y N P
Weakness Y N P
Dislocations Y N P
Other _____

Neurologic
Fainting Y N P
Seizures Y N P
Paralysis Y N P
Numbness/Tingling Y N P
Loss of Memory Y N P
Other _____

Mental/Emotional
Depression Y N P
Mood Swings Y N P
Anxiety Y N P
Memory Problems Y N P
Brain Fog Y N P
Poor Concentration Y N P
Other_____

Blood
Anemia Y N P
Easy Bruising Y N P
Other _____