INTEGRATIVE WELLNESS SOLUTIONS

Patient Information

Name _____ Date _____

Age _____ Date of birth _____ Male/Female

Address _____ City _____ State ____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell)_____

Email _____

Emergency Contact _____ Relationship _____

Telephone (Home) _____ (Work) _____ (Cell) _____

How did you hear about Dr. Greer? _____

Name and Phone Number of Your Primary Care Physician: _____

_____

HEALTH HISTORY

When, where, and by whom did you last receive medical care? _____

_____

In your opinion, what are your most important health problems? These problems can be physical, mental or emotional. Indicate which is/are of the most immediate concern to you.

1. _____

2. _____

3. _____

4. _____

5. _____

How do you rate your overall health? Excellent Good Fair Poor

What are your expectations for your first visit? _____

What are your expectations for our work together in general? _____

_____

How committed are you to making changes to improve your health?

1 2 3 4 5 6 7 8 9 10

Not Committed *Extremely committed*

HOSPITALIZATION

What hospitalizations or surgeries have you had? When did they occur?

_____

_____

_____

HEALTH STUDIES

When was your last blood test? _____ What type of test? _____

What is your blood type?_____

Any other tests recently? _____

MEDICATIONS

List all drugs, vitamins, herbs being taken at present with dosage:

_____

_____

_____

Are you allergic to any medications or other substances? Y N

If yes, please list _____

_____

What happens when you have an "allergy attack"? _____

CHILDHOOD ILLNESSES

Rubella (German Measles) ___ Measles ___ Mumps ___ Chickenpox ___ Roseola ___

Whooping cough ___ Polio ___ Rheumatic Fever ___ Scarlet Fever ___ Diphtheria ___

Frequent ear infections or colds as a child? _____ Asthma ___ Eczema ____

Any difficulties with your birth or your mother's pregnancy with you?_____

IMMUNIZATIONS

Polio	Y N	Pertussis	Y N
Tetanus	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Other _____	

FAMILY HISTORY

Please list ages, any major health problems, and if deceased, what they died from and at what age.

Mother _____

Father _____

Your Sisters _____

Your Brothers _____

Mother's Side:

Grandfather _____

Grandmother _____

Father's Side:

Grandfather _____

Grandmother _____

SOCIAL HISTORY

Occupation _____ Work hours_____

Are you: Married ___ Separated ___ Divorced ___ Single ___ Widowed ___ Partner ___

With whom do live: Spouse ___ Parents ___ Relatives ___ Friends ___ Alone ___ Other ___

Do you have the support of family and friends to make positive changes in your life? _____

Have you traveled outside the U.S? _____ Where and when? _____

Military Status: When did you serve? _____ Where? _____

Do you have a religious or spiritual practice? _____

In what areas of your life do you experience stress? Work Family Life Social Life Financial

Please list the most significant stressful events of your life (remember to include childhood):

1. _____
2. _____
3. _____
4. _____
5. _____

HEALTH HABITS

Do you drink alcohol? ____ If so, what: Wine ____ Beer ____ Other alcohol_____

Do you use tobacco or have you in the past? _____ If so, how much? _____

Total number of years smoking? _____ Total number of years since stopped smoking? _____

Do you now or have in the past used marijuana or other drugs? ____ If yes, which drugs, how often and for how long? _____

List any longterm health problems that have resulted from taking these drugs _____

Do you exercise? _____

How often? (Hours/day and days/week) _____

Circle any of the following that you do on a regular basis:

Run Swim Walk Bicycle Garden Yoga Stretch Weights Hike Other _____

Do you make time for rest, relaxation during the day and/or before bed? ____ How often? _____

How do you relax? _____

What are your primary interests or hobbies? _____

DIET

Number of meals eaten per day: 1 2 3 more than 3

How is your appetite? _____

Where do you usually buy your food? _____Who cooks the food you eat? _____

List the primary foods included in your diet. _____

_____

List the foods excluded from your diet. _____

_____

List any of the following (and relative amounts) eaten regularly by you: Coffee, caffeinated teas, highly seasoned foods, processed foods, preservatives, refined foods or foods you suspect may be harmful to your health:_____

List any of the foods you crave, regardless of their nutritional value (including sweets, chocolate, salty, sour, bread, rich/fatty foods, etc.): _____

Are you satisfied with your diet as it is now? ____ If not, why not? _____

_____

SLEEP

Do you have trouble falling asleep? ____ If yes, what keeps you up? _____
Do you sleep straight through the night? ____ If not, what time do you usually wake? _____
Average number of hours you sleep _____ Do you wake refreshed? ____
Do you have recurring dreams or nightmares ? ____ If yes, what is the theme? _____
What position do you usually sleep in? _____
Is there a position you cannot sleep in? ____ If yes, which one? _____
How many pillows do you sleep on? _____ Nights sweats? _____

HOME ENVIRONMENT AND OTHER ENVIRONMENTAL EXPOSURES

Circle any of the following you routinely use at home:

Gas heat Oil heat Electric heat Wood stove Air conditioning Electric blanket T.V.
Distilled / Filtered / Spring / Well / Tap water

Is your home and work environment well ventilated? _____
Is your home or work environment excessively damp or moist? _____
Please circle any of the following you feel most bothered by:

Sunshine Lack of sunshine Dampness Dryness Cold Heat Dust/Mold Cat/Dog hair
Car fumes Poor air/ventilation Fluorescent lighting Chemicals Perfumes

FEMALE REPRODUCTIVE HEALTH

Have you ever used birth control pills? ____ For how long? _____ What kind? _____
Have you ever used an I.U.D.? _____ For how long? _____ What kind? _____
Hormone replacement therapy? _____ For how long? _____ What kind? _____
Are you currently sexually active? _____ Have you been sexually active in the past? _____
Current form/s of contraception _____
Age when menstrual periods began _____ Did you have a normal puberty? _____
Period every _____ days. Regular: Yes No
Periods usually last _____ days (average) Date of last period _____
Quality of blood? (i.e. dark red, bright red, clots) _____
Amount of flow (i.e. # of pads or tampons/day) _____
Pain or cramping? _____ PMS? _____
Date of last PAP smear _____ Have you ever had an abnormal PAP? _____
Do you currently, or have had in the past, problems with infertility _____ if yes, explain _____
_____
Number of: pregnancies _____ births _____ miscarriages _____ abortions _____
Any complications of pregnancy? _____ If yes, explain _____
Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 (please circle one, 0 = none)
Any sexual problems? _____
Have you had any of the following concerning your breasts: Pain Lumps Infection Nipple discharge

MALE REPRODUCTIVE HEALTH

Are you currently sexually active? _____ Have you been sexually active in the past? _____
Type of contraception used? _____
Have you had any of the following: Testicular pain Prostate problems Hernia Discharges Sores
Have you had a prostate exam? _____ If so, when? _____
Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 (please circle one, 0 = none)
Any sexual problems? _____

MEDICAL HISTORY

Please circle:

O= occasionally Y = condition you have now N = never had this problem P= conditon you have had in the past

GENERAL

Weight _____

Weight one year ago_____

Maximum weight _____

When?_____

Height _____

Last physical exam? _____

ENERGY				
Fatigue	O	Y	N	P

SKIN				
Rashes	O	Y	N	P
Eczema, hives	O	Y	N	P
Itching	O	Y	N	P
Color change	O	Y	N	P
Lumps	O	Y	N	P

HEAD				
Head aches	O	Y	N	P
Head injury	O	Y	N	P

EYES				
Impaired vision	O	Y	N	P
Eye pain	O	Y	N	P
Tearing/dryness	O	Y	N	P
Double vision	O	Y	N	P
Glaucoma	O	Y	N	P
Cataracts	O	Y	N	P

EARS				
Impaired hearing	O	Y	N	P
Ringing	O	Y	N	P
Earache	O	Y	N	P

NOSE and SINUSES				
Frequent colds	O	Y	N	P
Nose bleeds	O	Y	N	P
Stuffiness	O	Y	N	P
Hay fever	O	Y	N	P
Sinus problems	O	Y	N	P

MOUTH and THROAT				
Frequent sore throat	O	Y	N	P
Sore Tongue	O	Y	N	P
Gum problems	O	Y	N	P
Hoarseness	O	Y	N	P
Dental cavities	O	Y	N	P

Last dental exam? _____

RESPIRATORY				
Cough	O	Y	N	P
Sputum	O	Y	N	P
Spitting up blood	O	Y	N	P
Wheezing	O	Y	N	P
Asthma	O	Y	N	P
Bronchitis	O	Y	N	P
Pneumonia	O	Y	N	P
Pleurisy	O	Y	N	P
Emphysema	O	Y	N	P
Trouble breathing	O	Y	N	P
Pain on breathing	O	Y	N	P
Short of breath	O	Y	N	P
At night	O	Y	N	P
Lying down	O	Y	N	P
Tuberculosis	O	Y	N	P

CARDIOVASCULAR				
Heart disease	O	Y	N	P
Angina	O	Y	N	P
Hypertension	O	Y	N	P
Murmurs	O	Y	N	P
Rheumatic fever	O	Y	N	P
Chest pain	O	Y	N	P
Swelling in ankles	O	Y	N	P
Palpitations	O	Y	N	P

URINARY				
Pain on urination	O	Y	N	P
Increased frequency	O	Y	N	P
Frequency at night	O	Y	N	P
Unable to hold urine	O	Y	N	P
Frequent infections	O	Y	N	P
Kidney stones	O	Y	N	P

EXTREMITIES				
Deep leg pain	O	Y	N	P
Cold hands/feet	O	Y	N	P
Varicose veins	O	Y	N	P
Thrombophebitis	O	Y	N	P
Nail Fungus	O	Y	N	P
Restless legs	O	Y	N	P

EMOTIONAL				
Anxiety, panic	O	Y	N	P
Depressed, hopeless	O	Y	N	P
Mood swings	O	Y	N	P
Weeping	O	Y	N	P
Compulsions	O	Y	N	P
Excessive anger	O	Y	N	P
Restless, bored	O	Y	N	P

GASTROINTESTINAL				
Belching/gas	O	Y	N	P
Gall bladder	O	Y	N	P
Heartburn	O	Y	N	P
Indigestion	O	Y	N	P
Liver problems	O	Y	N	P
Jaundice	O	Y	N	P
Vomiting	O	Y	N	P
Vomiting blood	O	Y	N	P
Blood in stool	O	Y	N	P
Change in thirst	O	Y	N	P
Change in appetite	O	Y	N	P
Binge eating	O	Y	N	P
Abdominal cramps	O	Y	N	P
Hemorrhoids	O	Y	N	P
Constipation	O	Y	N	P
Diarrhea	O	Y	N	P

MUSCULOSKELELTAL				
Joint pain, stiffness	O	Y	N	P
Arthritis	O	Y	N	P
Broken bones	O	Y	N	P
Muscle spasms	O	Y	N	P
Weakness	O	Y	N	P

NECK				
Lumps	O	Y	N	P
Swollen glands	O	Y	N	P
Goiter	O	Y	N	P

BLOOD				
Easy bruising	O	Y	N	P
Anemia	O	Y	N	P

ENDOCRINE				
Hypothyroid	O	Y	N	P
Hyperthyroid	O	Y	N	P
Low blood sugar	O	Y	N	P
Diabetes		Y	N	

NEUROLOGICAL				
Fainting	O	Y	N	P
Seizures	O	Y	N	P
Paralysis	O	Y	N	P
Numbness/tingling	O	Y	N	P
Memory loss	O	Y	N	P

WHEEL OF LIFE

Vitality and health are a balance of many factors. Using the pie graph below, please shade your level of satisfaction in each area as it relates to you . For example: if you are extremely happy in your job, shade the entire pie shape for "Career." Do the same for each area, starting from the center point radiating outwards. ("Serivce" relates to giving back to the community and volunteering.)