Waller Wellness Center

HCG Patient Health History

Demographic Information

Name (last, first, MI)			Social Security No.		Birthdate
Age	Sex	Marital Status M / S / D	Home Phone ( )		Work Phone ( )
Home Address (street, city, state and zip code)				Cell Phone ( )	
				Email Address	
Employer			Job Title		
Emergency Contact (Name)		Contact (Phone)		Who referred you?	
Personal Physician (Name and Address) Office Phone:				Preferred Pharmacy Name/Phone	

History

This section is for the purpose of learning more about your health history. Please read and answer all of the following questions to the best of your knowledge.

Reason for Consultation

What health concern and symptoms brings you to the clinic?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

_____ _____

List current health problems for which you are being treated: _____

_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Current medications (prescription or over-the-counter): _____

_____

_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

_____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)?

_____

What are your current health goals: _____

_____

_____

_____

_____

Medical History

❑ Arthritis
❑ Allergies/hay fever
❑ Asthma
❑ Alcoholism
❑ Alzheimer's disease
❑ Autoimmune disease
❑ Blood pressure problems
❑ Bronchitis
❑ Cancer
❑ Chronic fatigue syndrome
❑ Carpal tunnel syndrome
❑ Cholesterol, elevated
❑ Circulatory problems
❑ Colitis
❑ Dental problems
❑ Depression
❑ Diabetes
❑ Diverticular disease
❑ Drug addiction
❑ Eating disorder
❑ Epilepsy
❑ Emphysema
❑ Eyes, ears, nose, throat problems
❑ Environmental sensitivities
❑ Fibromyalgia
❑ Food intolerance
❑ Gastroesophageal reflux disease
❑ Genetic disorder
❑ Glaucoma
❑ Gout
❑ Heart disease
❑ Infection, chronic
❑ Inflammatory bowel disease
❑ Irritable bowel syndrome
❑ Kidney or bladder disease
❑ Learning disabilities
❑ Liver or gallbladder disease (stones)
❑ Mental illness
❑ Mental retardation
❑ Migraine headaches
❑ Neurological problems (Parkinson's, paralysis)
❑ Sinus problems
❑ Stroke
❑ Thyroid trouble
❑ Obesity
❑ Osteoporosis
❑ Pneumonia
❑ Sexually transmitted disease
❑ Seasonal affective disorder
❑ Skin problems
❑ Tuberculosis
❑ Ulcer
❑ Urinary tract infection
❑ Varicose veins
Other _____
_____

Medical (Men)

❑ Benign prostatic hyperplasia
❑ Prostate cancer
❑ Decreased sex drive
❑ Infertility
❑ Sexually transmitted disease
Other _____
_____

Medical (Women)

❑ Menstrual irregularities
❑ Endometriosis
❑ Infertility
❑ Fibrocystic breasts
❑ Fibroids/ovarian cysts
❑ Premenstrual syndrome (PMS)
❑ Breast cancer
❑ Pelvic inflammatory disease
❑ Vaginal infections
❑ Decreased sex drive
❑ Sexually transmitted disease
Other _____
Date of last GYN exam _____
Mammogram ❑ + ❑ –
PAP ❑ + ❑ –
Form of birth control _____
# of children _____
# of pregnancies _____
❑ C-section _____
Age of first period _____
Date - last menstrual cycle _____
Length of cycle _____ days
Interval of time between cycles _____days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
❑ Surgical menopause
❑ Menopause

Family Health History (Parents and Siblings)

❑ Arthritis
❑ Asthma
❑ Alcoholism
❑ Alzheimer's disease
❑ Cancer
❑ Depression
❑ Diabetes
❑ Drug addiction
❑ Eating disorder
❑ Genetic disorder
❑ Glaucoma
❑ Heart disease
❑ Infertility
❑ Learning disabilities
❑ Mental illness
❑ Mental retardation
❑ Migraine headaches
❑ Neurological disorders (Parkinson's, paralysis)
❑ Obesity
❑ Osteoporosis
❑ Stroke
❑ Suicide
Other _____

Health Habits

❑ Tobacco:
Cigarettes: #/day _____
Cigars: #/day _____
❑ Alcohol:
Wine: #glasses/d or wk _____
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____
❑ Caffeine:
Coffee: #6 oz cups/d _____
Tea: #6 oz cups/d _____
Soda w/caffeine: #cans/d _____
Other sources _____
❑ Water: #glasses/d_____

Exercise

❑ 5-7 days per week
❑ 3-4 days per week
❑ 1-2 days per week
❑ 45 minutes or more duration per workout
❑ 30-45 minutes duration per workout
❑ Less than 30 minutes
❑ Walk - #days/wk _____
❑ Run, jog, other aerobic - #days/wk _____
❑ Weight lift - #days/wk_____
❑ Stretch - #days/wk_____
❑ Other _____

Nutrition & Diet

❑ Mixed food diet (animal and vegetable sources)
❑ Vegetarian
❑ Vegan
❑ Salt restriction
❑ Fat restriction
❑ Starch/carbohydrate restriction
❑ The Zone Diet
❑ Total calorie restriction
Specific food restrictions:
❑ dairy ❑ wheat ❑ eggs
❑ soy ❑ corn ❑ all gluten
Other _____

Food Frequency

Number of servings per day:
Fruits (citrus, melons, etc.) _____
Dark green or deep yellow/orange vegetables _____
Grains (unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

Eating Habits

❑ Skip meals - which ones _____
_____
❑ One meal/day
❑ Two meals/day
❑ Three meals/day
❑ Graze (small frequent meals)
❑ Generally eat on the run
❑ Eat constantly whether hungry or not

Current Supplements

❑ Multivitamin/mineral
❑ Vitamin C
❑ Vitamin E
❑ EPA/DHA
❑ Evening Primrose/GLA
❑ Calcium, source _____
❑ Magnesium
❑ Zinc
❑ Minerals, describe _____
❑ Friendly flora (acidophilus)
❑ Digestive enzymes
❑ Amino acids
❑ CoQ10
❑ Antioxidants (e.g., lutein, resveratrol, etc.)
❑ Herbs
❑ Homeopathy
❑ Protein shakes
❑ Superfoods (e.g., bee pollen, phytonutrient blends)
❑ Liquid meals (Ensure)
Others _____
_____

I Would Like To:

ENERGY - VITALITY

❑ Feel more vital
❑ Have more energy
❑ Have more endurance
❑ Be less tired after lunch
❑ Sleep better
❑ Be free of pain
❑ Get less colds and flu
❑ Get rid of allergies
❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
❑ Stop using laxatives and stool softeners
❑ Improve sex drive

BODY COMPOSITION

❑ Loose weight
❑ Burn more body fat
❑ Be stronger
❑ Have better muscle tone
❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

❑ Learn how to reduce stress
❑ Think more clearly and be more-focused
❑ Improve memory
❑ Be less depressed
❑ Be less moody
❑ Be less indecisive
❑ Feel more motivated

LIFE ENRICHMENT

❑ Reduce my risk of degenerative disease
❑ Slow down accelerated aging
❑ Maintain a healthier life longer
❑ Change from a "treating-illness" orientation to creating a wellness lifestyle

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FirstLine Therapy™ Health Profile

NAME _____ DATE _____ WEEK _____

Rate each of the following symptoms based upon your typical health profile for: ☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale		
0	*Never* or *almost never* have the symptom	3 *Frequently* have it, effect is *not severe*
1	*Occasionally* have it, effect is *not severe*	4 *Frequently* have it, effect is *severe*
2	*Ocasionally* have it, effect is *severe*	

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ TOTAL

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near- or far-sightedness)
_____ TOTAL

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ TOTAL

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ TOTAL

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums or lips
_____ Canker sores
_____ TOTAL

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ TOTAL

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ TOTAL

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ TOTAL

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
_____ TOTAL

JOINTS / MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ TOTAL

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ TOTAL

ENERGY / ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ TOTAL

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ TOTAL

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
_____ TOTAL

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ TOTAL

GRAND TOTAL _____