Patient Intake & Health History

Dr. Sherie Viencek, DC

Please print clearly

NAME: _____ **DATE:** _____

ADDRESS: _____ **APT.NO:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

E-MAIL: _____

HOME PHONE: _____ **WORK/CELL:** _____

REFERRED BY: _____

OCCUPATION: _____ **EMPLOYER:** _____

DATE OF BIRTH: _____ **AGE:** _____

SEX: ☐ **M** ☐ **F** **HEIGHT:** _____ **WEIGHT:** _____

OVERALL HEALTH *(Check one)*: ☐ **EXCELLENT** ☐ **GOOD** ☐ **FAIR** ☐ **POOR** ☐ **OTHER**

CHIEF COMPLAINT *(Reason you are here. Use separate sheet if more space is needed.)*

PREVIOUS TREATMENTS FOR THIS COMPLAINT *(Please explain)*

LIST ANY MAJOR ILLNESSES, ACCIDENTS, AND SURGERIES *(With approximate dates)*

CURRENT MEDICATIONS/AND REASONS FOR TAKING THEM

DID YOU TAKE ANY OF THESE MEDICATIONS FOR MORE THAN SIX MONTHS?

☐ Antibiotics ☐ Antidepressants ☐ Beta blockers ☐ Birth control pills ☐ Diuretics

☐ Statins ☐ Stomach acid reducers ☐ Steroids ☐ Other: _____

NUTRITIONAL SUPPLEMENTS YOU ARE TAKING

_____

_____

_____

NAME OF YOUR CURRENT PRIMARY CARE PHYSICIAN: _____

ARE YOU CURRENTLY UNDER THE CARE OF OTHER HEALTH CARE PROFESSIONIALS? *(Please explain)*

_____

_____

PLEASE DESCRIBE THE HEALTH OF SPOUSE/PARTNER: _____

DO YOU HAVE ANY CHILDREN? HOW MANY & AGES: _____

DO YOUR CHILDREN HAVE ANY PHYSICAL CONDITIONS OR CONCERNS? ☐ NO ☐ YES *(Please explain)*

_____

ANY HOUSEHOLD PETS YOU OR YOUR FAMILY MEMBERS ARE IN CONTACT WITH? _____

CHILDHOOD HISTORY

ANY COMPLICATIONS AT THE TIME OF YOUR BIRTH? ☐ NO ☐ YES _____

ANY SPECIFIC HEALTH ISSUES DURING INFANCY OR EARLY CHILDHOOD? ☐ NO ☐ YES _____

WERE THERE ANY FOOD &/OR ENVIRONMENATAL ALLERGIES, SENSITIVITIES, OR REACTIONS IN YOUR CHILDHOOD? ☐ NO ☐ YES _____

DO YOU PRESENTLY HAVE ANY ALLERGIES OR SENSITIVITIES? ☐ NO ☐ YES _____

WAS THERE EVER A BAD REACTION TO A VACCINE OR FLU SHOT? ☐ NO ☐ YES _____

WHERE YOU EVER EXPOSED TO HEAVY METALS, CHEMICALS, PESTICIDES, HERBICIDES AS A CHILD? *(Please explain)*

_____

_____

DENTITION

DO YOU HAVE ANY AMALGAM FILLINGS? ☐ YES ☐ NO **ROOT CANALS?** ☐ YES ☐ NO

CAPS? ☐ YES ☐ NO **IMPLANTS?** ☐ YES ☐ NO **DENTURES?** ☐ YES ☐ NO

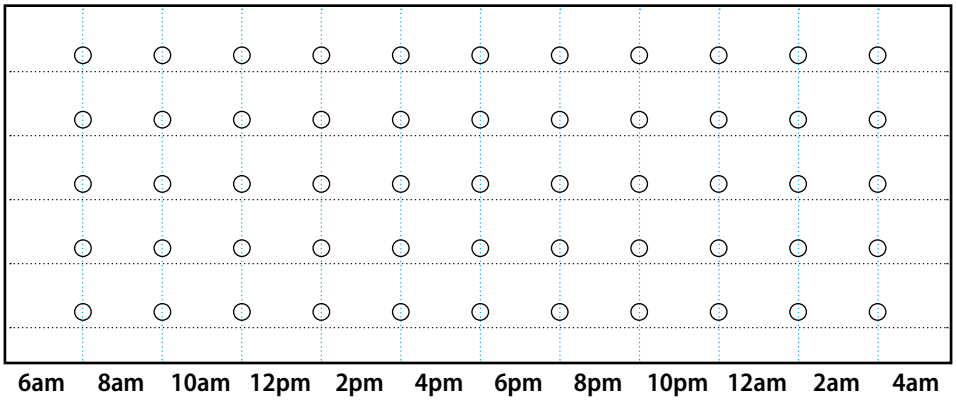
HAVE YOU HAD ANY AMALGAM FILLINGS REMOVED? ☐ YES ☐ NO **WHEN?** _____

GUM SURGERY OR GINGIVITIS? ☐ YES ☐ NO **OTHER ORAL PROBLEMS?** _____

ENERGY

ON A SCALE OF 1 TO 5 *(1 being the lowest, 5 the highest)* **WHAT IS YOUR OVERALL LEVEL OF ENERGY?** _____

DO YOU HAVE PEAKS AND SLUMPS DURING THE COURSE OF THE DAY? *(Please show the pattern below)*



ARE YOU AWARE OF ANY PATTERNS IN THE WAY YOUR ENERGY VARIES? ☐ **NO** ☐ **YES** *(Please explain)*

WHAT IS YOUR FAVORITE TIME OF DAY? _____

WHAT HAPPENS? _____

WHAT IS YOUR LEAST FAVORITE TIME OF DAY? _____

WHAT HAPPENS? _____

STRESS

CHECK THE LEVEL OF STRESS YOU ARE EXPERIENCING ON A SCALE OF 1-10 *(1 being the lowest)*

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

IDENTIFY THE MAJOR CAUSES OF STRESS *(Changes of job, residence, family, financial, etc.)*

IS YOUR JOB ASSOCIATED WITH HIGH STRESS LEVELS OR POTENTIAL HARMFUL CHEMICALS, SUCH AS PESTICIDES, SOLVENTS, ETC?

MOODS AND EMOTIONS

DO YOUR MOODS TEND TO BE: ☐ **EVEN/STABLE** ☐ **VARIABLE**

DO YOU EASILY BECOME IRRITABLE, IMPATIENT OR ANGRY? ☐ **YES** ☐ **NO**

ARE MOOD SWINGS A PROBLEM, AND IN WHAT WAY? ANY CONTRIBUTING FACTORS, OR TRIGGERS?

SLEEP

WHAT ARE YOUR USUAL HOURS OF SLEEP? FROM _____ TO _____ DAYTIME NAPS? ☐ YES ☐ NO

DO YOU FIND YOURSELF DOSING DURING THE DAY? ☐ YES ☐ NO

DO YOU HAVE TROUBLE FALLING ASLEEP? ☐ YES ☐ NO

DO YOU SLEEP WELL, AND FEEL RESTED UPON AWAKENING? ☐ YES ☐ NO

DO YOU HAVE PERIODS OF DEEP SLEEP? ☐ YES ☐ NO DO YOU AWAKE AT NIGHT? ☐ YES ☐ NO

IF YES, WHAT TIME? _____ DO YOU STAY AWAKE OR FALL BACK TO SLEEP? _____

NIGHTMARES OR RECURRENT BAD DREAMS? ☐ YES ☐ NO DO YOU SNORE? ☐ YES ☐ NO

DO YOUR ARMS OR LEGS "JUMP" AND WAKE YOU? ☐ YES ☐ NO DO YOU WAKE RESTED? ☐ YES ☐ NO

ANY OTHER ASPECTS OF YOUR SLEEP THAT MIGHT BE USEFUL TO KNOW? _____

DIGESTION

DO YOU HAVE ANY DIGESTIVE PROBLEMS? ☐ NO ☐ YES *(Please explain below)*

_____

_____

HOW OFTEN DO YOU MOVE YOUR BOWELS? _____

DO YOU HAVE ANY PROBLEMS WITH SWALLOWING, INDIGESTION, HEARTBURN, BLOATING, MALDIGESTION, IRREGULAR BOWEL MOVEMENTS, LOOSE STOOLS OR CONSTIPATION, INTESTINAL CANDIDIASIS, OR PARASITES? ☐ NO ☐ YES *(Please explain below)*

_____

IMMUME SYSTEM

HAVE YOU OR ANYONE IN YOUR FAMILY EVER BEEN DIAGNOSISED WITH AN AUTOIMMUME DISEASE?

☐ NO ☐ YES _____

HAS ANYONE IN YOUR EXTENDED FAMILY EVER BEEN DIAGNOSED WITH CELIAC DISEASE? ☐ YES ☐ NO

HAVE YOU HAD ANY GENETIC LAB TESTING DONE? WHAT WERE THE RESULTS? _____

WEIGHT HISTORY

CURRENT HEIGHT _____ CURRENT WEIGHT _____ HOW LONG AT THIS LEVEL? _____

DO YOU CONSIDER YOURSELF ☐ UNDERWEIGHT ☐ OVERWEIGHT ☐ JUST RIGHT

HAVE YOU HAD WEIGHT ISSUES IN THE PAST? ☐ NO ☐ YES _____

ANY HISTORY OF EATING DISORDERS? ☐ NO ☐ YES _____

PHYSICAL ACTIVITY

TYPE OF WORK: ☐ **SEDENTARY** ☐ **MODERATELY ACTIVE** ☐ **VERY ACTIVE**

HOW OFTEN DO YOU EXERCISE? _____

ANY LIMITING FACTORS, SUCH AS MUSCULO-SKELETAL PAIN, SHORTNESS OF BREATH, RAPID OR IRREGULAR HEARTBEAT, CHEST PAIN, FATIGUE? ☐ **NO** ☐ **YES** *(Please explain below)*

_____

RECENT TESTS (Men and Women)

	DATE	RESULTS
BLOOD PRESSURE		
CHOLESTEROL OR OTHER LIPID EVALUATIONS		
DENTAL EXAM & TEETH CLEANING		
EYE EXAM (VISUAL ACUITY & INTEROCULAR PRESSURE)		
RECTAL EXAM W/EVAL OF STOOL FOR OCCULT BLOOD		
COLONOSCOPY		
BONE DENSITY		
VITAMIN D		
GYNECOLOGICAL EXAM WITH PAP SMEAR		
BREAST EXAM		
MAMMOGRAM		
PSA TEST		

WOMEN ONLY

AGE AT FIRST MENSTRUAL CYCLE _____ **ARE/WERE YOUR CYCLES REGULAR?** ☐ **YES** ☐ **NO**

DAYS BETWEEN PERIODS? _____ **DURATION OF FLOW** _____ ☐ **LIGHT** ☐ **MODERATE** ☐ **HEAVY**

ANY PREMENSTRUAL SYMPTOMS?

☐ **Breast Tenderness** ☐ **Headache** ☐ **Lower Back Pain** ☐ **Bloating** ☐ **Cramping** ☐ **Constipation**
☐ **Diarrhea** ☐ **Skin/Acne** ☐ **Mood Changes** ☐ **Appetite/Cravings** ☐ **Other** _____

DO/DID THE ABOVE SYMPTOMS GET BETTER WITH FLOW? ☐ **YES** ☐ **NO**

CURRENT METHOD OF BIRTH CONTROL: _____

DATE OF YOUR LAST MENSTRUAL CYCLE: _____

IF NO LONGER MENSTRUATING, AGE AT CESSATION OF MENSES: _____

CURRENT MENOPAUSAL SYMPTOMS:

_____

_____

ARE YOU ON HORMONE THERAPY? ☐ **NO** ☐ **YES** *(Type, Dose, Duration)* _____

ANY LIBIDO ISSUES OR CONCERNS? _____

DO YOU HAVE RECURRING VAGINAL OR BLADDER INFECTIONS? ☐ **YES** ☐ **NO**

DO YOU HAVE ANY OTHER CONCERNS REGARDING WOMEN'S HEALTH ISSUES?

_____

_____

SUBMIT FORM

(drvvitalhealth@gmail.com)