HWNC

3234 West Truman Blvd

Jefferson City, MO 65109

573-893-9999

Dianna@drhwnc.com

www.drhwnc.com

Release Form

I____ understand disclosure of all medical conditions and medication whether prescription or supplement is vital to creating a wellness program that will benefit my overall health. I also understand any and all advice or directions should be followed exactly to achieve desired results.

Should it be necessary to contact my other physicians for additional information to assist in my health improvements, I hereby give that permission with my signature on this form.

____ _________________________

Name Date

HWNC Client Intake Form

I. PERSONAL INFORMATION Today's Date ______________________

Full Name____

(First Middle Initial Last) Date of Birth_________________________ Gender ___________

Address____City___________________________________

Phone (best to be reached) _____________________________

Occupation____

Are you: Married____ Single_____ Separated____ Cohabitating_____ Divorced____ Widowed___

Live with: Spouse_____ Children_____

Children's Ages____________________________________

Emergency Contact (name and relation) ____

Contact's Phone ____

II. MEDICAL HISTORY

What are your most important health challenges? List as many as you can in order of importance.

____

____

____

Have you consulted any other physician or health practitioner? When and for what?

____

____

____

____

Your Email____

What is your blood type (A/B/O)_______

Do you have any body parts that are not your own? (Implants, transplants)?____

Weight _____ Weight 1 year ago _____ Maximum Weight _____ When? ____________

What childhood illnesses have you had? Please list approximate year or age:

____

____

Did you have standard childhood immunizations? ______________

Immunizations for travel outside the US? Which ones and when? ____________

Any negative reactions? Explain______________________________________

Approximately how many times in your life have you had antibiotics? ___________

What hospitalizations or surgeries have you had? Please list date.

____

III. FAMILY HISTORY

Do your close relatives (parents, siblings, children) have any of the following medical conditions? Please circle and indicate the relative with the disease:

Disease

High Blood Pressure _____________ Heart Attack _________________ Stroke_____________________

Obesity_______________________ Diabetes_______________________ Glaucoma _______________

Asthma_______________________ Hay Fever________________ Food Allergies_________________

Eczema ______________________ Skin Disease________________ Arthritis______________

Emphysema________________ Tuberculosis________________ Gout__________________

Lung Cancer________________ Ulcers__________________ Sickle Cell Anemia________

Breast Cancer_______________ Thyroid Disease_________ Osteoporosis_____________

Other Cancer________________ Epilepsy___________________ Easy Bleeding____________

Birth Defects________________ Suicide________________ Depression__________________

Other____________________ Mental Illness_______________ Alcoholism_________________

MTHFR_________________

IV. REVIEW OF SYMPTOMS

Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you *Now* or in the *Past*.

	Now	Past		Now	Past	
General	___	___	swollen or painful lymph nodes	___	___	excessive hair growth
	___	___	wounds heal slowly	___	___	bruise easily
	___	___	difficulty stopping bleeding	___	___	can't stand heat
	___	___	anemia	___	___	can't stand cold
	___	___	bleeding from unusual places	___	___	cold hands or feet
	___	___	unexplained fever	___	___	night sweats
	___	___	weakness	___	___	increased thirst
	___	___	fatigue	___	___	increased hunger
	___	___	unexplained weight loss/gain	___	___	excess sweating
Skin and Nails	___	___	pimples	___	___	hives
	___	___	color changes in nails	___	___	loss of hair
	___	___	infections			
	___	___	skin rough, dry, scaly, bumpy, itchy (circles which applies)			
	___	___	rashes, warts, moles, cysts (circles which applies)			
	___	___	light or dark patches of skin (circles which applies)			
	___	___	increased hair growth in unusual places			
Head	___	___	dizziness	___	___	double vision
	___	___	headaches	___	___	fainting spells
	___	___	seizures or fits	___	___	injuries
Eyes	___	___	corrective lenses	___	___	pain, irritation
	___	___	infections	___	___	discharge
	___	___	injuries	_______________		last exam
Ears	___	___	discharge	___	___	infections
	___	___	pain in ears	___	___	injuries
	___	___	hearing trouble	___	___	ringing or roar in ear
	___	___	itching	___	___	stopped up ears
	___	___	motion sickness	_______________		other
Nose	___	___	nosebleeds	___	___	injury
	___	___	sinus problems	___	___	loss of smell
	___	___	discharge/crusts	___	___	polyps
	___	___	sneezing attacks	___	___	ulcers
	___	___	difficulty breathing through nose	_______________		other
Mouth	___	___	sores	___	___	poor dentition
	___	___	speech difficulties	___	___	infections
	___	___	loss of teeth	___	___	dryness
	___	___	grinding teeth	___	___	bad breath
	___	___	sore jaw	___	___	bad taste
	___	___	gum problems	___	___	root canals
	___	___	amalgam fillings	_______________		other

Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you *Now* or in the *Past*.

	Now	Past		Now	Past	
Throat	___	___	loss of voice	___	___	pain
	___	___	infections	___	___	swelling/constriction
	___	___	persistent hoarseness	___	___	difficulty swallowing
Neck	___	___	stiffness	___	___	injuries
	___	___	swollen glands,	___	___	enlarged thyroid
Respiratory						
	___	___	shortness of breath	___	___	wheezing/asthma
	___	___	coughing spells	___	___	infections
	___	___	expectoration (mucus, blood)	___	___	chest pain with breath
Cardiovascular						
	___	___	chest pain	___	___	leg vein trouble
	___	___	shortness of breath	___	___	murmur
	___	___	irregular beat	___	___	ankle or foot swelling
	___	___	feel heart pounding/racing	___	___	leg pain walking
Gastrointestinal						
	___	___	nausea	___	___	vomiting
	___	___	blood in stool	___	___	diarrhea
	___	___	constipation	___	___	hemorrhoids
	___	___	hard, dry stools	___	___	vomiting blood
	___	___	ulcer	___	___	bloating
	___	___	anal itching	___	___	indigestion
	___	___	heavy, full feeling after eating	___	___	heartburn
	___	___	excess belching	___	___	parasites
	___	___	trouble swallowing	___	___	abdominal pain
	___	___	foul-odored stools	___	___	excessive gas
	___	___	irritable if late for meal	___	___	sleepy during day
	___	___	nervous shaky feelings, headaches, relieved by eating			
	___	___	alternating constipation and diarrhea			
	___	___	change in bowel movements			

How often do you have bowel movements?____

	Now	Past		Now	Past	
Urinary	___	___	frequent urination	___	___	painful urination
	___	___	night urination	___	___	foul odor of urine
	___	___	trouble starting urine	___	___	trouble holding urine
	___	___	urine dark, cloudy, foamy, bloody (circle which applies)			
Male	___	___	discharge from penis	___	___	painful erection
	___	___	infertility	___	___	infection
	___	___	prostate problems	___	___	injury
	___	___	difficulty achieving or maintaining an erection			
	___	___	lumps, swelling, or pain in testicles			

What kind of contraception do you use?____

Do you want birth control information?____

Please mark 1 (mild), 2 (moderate), or 3 (severe) if any of the following apply to you *Now* or in the *Past*.

	Now	Past		Now	Past	
Female	___	___	discharge from vagina	___	___	painful intercourse
	___	___	pelvic pain	___	___	flushes of heat
	___	___	infertility			
	___	___	difficulty feeling sexually aroused			
	___	___	no lubrication when aroused			
	___	___	never or seldom have orgasms			
	___	___	menstrual flow is excessive			
	___	___	menstrual flow is absent			
	___	___	bleeding/spotting before or after periods			
	___	___	breasts: lumps, swelling, soreness (circle)			
	___	___	infection: Type/Location__________________When?_________________			
	___	___	premenstrual symptoms: cramping, water retention, breast tenderness, headaches, depression, irritability, others, (circle)			

What kind of contraception do you use?____

Do you want birth control information?______________________________________

First day of last menstrual period____________________

Length of cycle______ days, Duration of menses______

Hysterectomy date___________________ Do you still have your ovaries?___________

Number of Pregnancies________Number of Births________Number of miscarriages______

Date of last annual exam / PAP ____________________

Musculoskeletal

Now	Past	
___	___	back pain
___	___	spinal curvature or scoliosis
___	___	muscle cramp. Where?___________________
___	___	joint pain or stiffness. Where?_____________
___	___	swelling. Where?_______________________
___	___	injury. Where?_________________________
___	___	other. Describe.________________________

Neurological

Now	Past		Now	Past	
___	___	loss of balance	___	___	paralysis
___	___	faintness	___	___	lack of strength
___	___	involuntary movement	___	___	speech slurred
___	___	loss of consciousness	___	___	convulsions (seizures)
___	___	tremor (shaking, trembling)	___	___	numbness. where?___

	Now	Past		Now	Past	
Mental	___	___	restlessness	___	___	nervousness/anxiety
	___	___	excessive worry	___	___	trouble sleeping
	___	___	memory trouble	___	___	crying spells
	___	___	trouble concentrating	___	___	depression
	___	___	nightmares	___	___	manic episodes
	___	___	excess stress	___	___	fogginess/confusion
	___	___	feel like killing myself	___	___	easily angered
	___	___	feel better from exercising	___	___	irritable
	___	___	feelings of worthlessness	___	___	mood swings
	___	___	trouble getting along with people	___	___	drug abuse
	___	___	physical or sexual abuse	___	___	other_____________
	___	___	difficulty expressing feelings			
	___	___	loss of someone dear through death or separation			
	___	___	don't know how to relieve stress			

Have you had any experiences (traumatic or otherwise) that did or still do affect you deeply? Explain if you wish:____

V. THERAPIES AND LIFESTYLE

Current Medications: Please list any prescription medications, nutritional supplements, herbs or homeopathic remedies you are currently taking. Please list doses if known. Bringing bottles with you to your visit is helpful.

Please list any medications, natural or prescription that you have tried in the past.____________________

Other therapies____

Are you allergic to any drugs?____

Do you use:	**YES**	**AMOUNT**		**YES**	**AMOUNT**
Alcohol	___	________________	Hormones	___	________________
Pain Relievers	___	________________	Laxatives	___	________________
Birth Control Pill	___	________________	Coffee/Caffeine	___	________________
Soda Pop	___	________________	Fast Food	___	________________
Cortisone	___	________________	Tobacco	___	________________
Electric Blanket	___	________________	Sleeping Aids	___	________________
Thyroid Medication	___	________________	Appetite Suppressants	___	________________
Antacids	___	________________	Sugar	___	________________
Recreational Drugs	___	________________			

How much sleep do you get a night?______ Is it enough?_____ Do you wake during the night?_______
Do you wake refreshed in the morning?__________

Are you exposed to chemicals, explain____

Are you under stress, explain____

Do you exercise?________ How often?_________ What type?__________________________________

V. NUTRITION

How much water do you drink a day?_______________ Do you use a water filter?_________________

Generally, what does your diet consist of?____

____

____

What times or how frequently do you eat?__________________ Who prepares your food?___________

Do you snack? On what?____

What food(s), condiments(s), or any other substances (e.g. tobacco, alcohol, coffee, etc.) do you crave?

____

Are you repelled by, or do you dislike any foods? Please identify:______________________________

____

Are there any foods that do not agree with you or aggravate you? Explain:________________________

____

VI. FINAL NOTES

What do you think causes or has contributed to your health problems?___________________________

____

What do you feel needs to happen for you to get better?_______________________________________

____

What do you enjoy most in your life?____

____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?_______________

____

____

How much change are you willing to make at this time for improving your health? (circle)

MINIMAL SOME COMPLETE

Is there anything else you wish to add?____

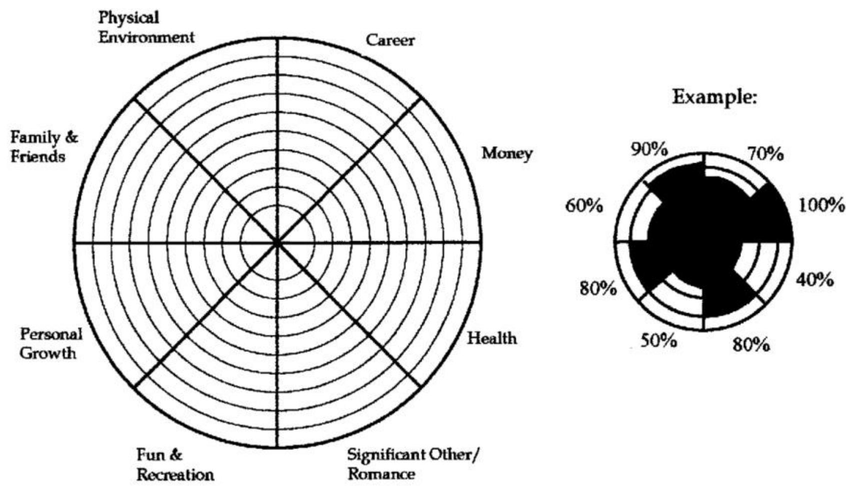
____

____

____

____

____



VII. WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

Thank you for taking the time to complete this form.
We look forward to providing you the best possible care.