HOLISTIC FAMILY WELLNESS

Initial Intake

NAME: ____TODAY'S DATE: _____________________

ADDRESS: ____

CITY: ____ STATE: ____________________ZIP: _________________

HOME PHONE: (___)_________________ WORK PHONE: (___)________________ MOBILE PHONE: (___)_________________

E-MAIL: ______________________________ OCCUPATION: ____________________ REFERRED BY: __________________

DATE OF BIRTH: _____________________ HEIGHT: _______________ WEIGHT: _________________

HAVE YOU EVER BEEN TO SEE A PRACTITIONER OF CHINESE HEALTHCARE BEFORE? _____ YES _____NO

LIST ALL HEALTHCARE PROVIDERS YOU PRESENTLY SEE. INCLUDE YOUR DOCTOR, CHIROPRACTOR, MASSAGE THERAPIST, ETC.

WHAT IS THE CHIEF COMPLAINT(S) OR CONCERN(S) THAT BRINGS YOU TO HOLISTIC FAMILY WELLNESS TODAY?

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. INCLUDE PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS THAT YOU TAKE REGULARLY OR OCCASIONALLY:

PLEASE LIST ALL SUPPLEMENTS, VITAMINS, HERBS, ETC. THAT YOU ARE CURRENTLY TAKING:

PLEASE LIST ALL MAJOR ILLNESSES, TRAUMAS, HOSPITALIZATIONS AND THEIR DATES OF OCCURRENCE:

PLEASE LIST ANY ALLERGIES THAT YOU HAVE:

PLEASE DISCUSS CURRENT AND PAST USE OF THE FOLLOWING:

CIGARRETTES: ALCOHOL:

COFFEE: SODA: RECREATIONAL DRUGS:

PLEASE DESCRIBE YOUR AVERAGE/DAILY/WEEKLY EXERCISE OR PHYSICAL ACTIVITY PATTERNS:

PLEASE DESCRIBE YOUR AVERAGE DAILY/WEEKLY DIET:

PLEASE INCLUDE ANY OTHER INFORMATION YOU FEEL IS IMPORTANT: