Whole Health Associates
1701 K. Street NW. Suite 801, Washington, DC 20006 202-822-1711

Name_____

Birthday_____ **Age**_____ **Gender:** _____

Address _____

City _____ **State**_____ **Zip**_____

Home Phone_____ **Cell Phone**_____

Work Phone _____ **Best Number to Reach Me: Home Cell Work (circle one)**

In addition to appointment reminders, a few times a year we send wellness related information via email. We hate SPAM too and we would never share your email with anyone!

Email address_____

Referred by_____ **May we thank them for your referral? Yes No**

(circle one) Married Single Partnered Divorced Widowed

Spouse/Partner _____

Children (Age & Gender)_____

Physician_____ **Phone**_____

Emergency Contact_____ **Phone**_____

Relationship_____

Goals: What would you like to address through treatment?

_____

_____

_____

_____

Medications / Supplements
(please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____

_____

_____

_____

Allergies (to medications, chemicals, foods)

_____

_____

LIFESTYLE

1. What is your occupation?_____

How many hours do you work weekly?_____

2. How many servings per day do you use of the following?

Coffee_____ Tea_____ Soft drinks_____ Alcohol_____ Water_____

Cigarettes, cigars, or other tobacco_____

Any recreational drugs?_____
(leave this blank if you not want it to be part of your written medical record and we can discuss during your first visit)

3. Do you crave sugar?_____

4. Describe your current diet (what you typically eat for meals and for snacks)

_____

_____

_____

5. Please describe your current exercise regimen:

Hours per week: _____ Activities: _____

6. How many hours of sleep do you usually get per night during the week? _____

Do you awake feeling rested? [ ] Yes [ ] No Do you sleep soundly? [ ] Yes [ ] No

Do you have trouble falling asleep [ ] Yes [ ] No Do you have trouble staying asleep[ ] Yes [ ] No

Do you get up at night to urinate? [ ] Yes [ ] No How often?_____

For Women:

1. **Age: First period _____ Menopause (if applicable) _____**
2. **Date: Last Pap Smear _____ Last Mammogram _____**
3. **Date of Last Menstrual Cycle_____**

a) Average number of days of flow _____ b) The flow is: [ ] Normal [ ] Heavy [ ] Light

c) The color is: [ ] Bright Red [ ] Dark Red [ ] Purple [ ] Light Brown [ ] Dark Brown

d) Days between periods:_____

2. Are you pregnant now? [ ]Yes [ ]No [ ]Unsure

3. Indicate number of occurrences: Live Births _____ Pregnancies_____

4. If interested in fertility treatment, please describe any concerns and methods used to date:

_____

_____

For Men:

1. Do you have any bothersome urinary or genital symptoms? [ ] Yes [ ] No

2. Any sexual dysfunction (erectile, etc.)? [ ] Yes [ ] No

3. Date /results of last PSA if applicable (prostate- specific antigen test) _____

PAIN

Are you experiencing pain/discomfort in any area of your body? Yes No (circle one)

Where in your body?
(For each body part, please indicate if pain is:
Sharp/stabbing ,Pins & Needles, Dull/Aching, Numb)

_____

_____

_____

_____

_____

_____

Hospitalizations / Surgical History

_____**Date _____**

_____**Date_____**

_____**Date_____**

General (please check all that apply)

□ Poor Appetite	□ Weakness	□ Low Energy	□ Hearing Loss	□ Fevers
□ Chills	□ Bruise Easy	□ Sweat Easily	□ Fatigue	□ Strong Thirst
□ Poor Sleep	□ Tremors	□ Edema	□ Poor Balance	□ Weight Loss
□ Night Sweats	□ Cravings	□ Weight Gain	□ Weight Loss	□ Changes in Appetite

Skin & Hair

□ Rashes	□ Itching	□ Dandruff	□ Skin Ulcers	□ Eczema
□ Hair Loss	□ Hives	□ Pimples	□ Recent Moles	

Head, Eyes, Ears, Nose, and Throat

□ Dizziness	□ Toothache	□ Blurry Vision	□ Cataracts	□ Ear Ringing
□ Sinus Problems	□ Headaches	□ Concussions	□ Eye Strain/Pain	□ Night Blindness
□ Poor Hearing	□ Nose Bleeds	□ Facial Pain	□ TMJ Pain	□ Migraines
□ Ear Aches	□ Floaters	□ Lip or Tongue Sores	□ Taste/Smell Problems	□ Recurrent Sore Throat

Cardiovascular

□ Blood Clots	□ Palpitations	□ Swelling of Hands	□ Swelling of Feet	□ Chest Pain
□ Phlebitis	□ Fainting	□ Lightheaded	□ High Blood Pressure	□ Low Blood Pressure
□ Irregular Heartbeat		□ Cold Hands/ Feet		

Respiratory

□ Cough	□ Bronchitis	□ Difficulty Breathing	□ Phlegm	□ Coughing Up Blood
□ Pneumonia	□ Asthma	□ Painful Breathing	□ Easily Winded	

Gastro-Intestinal

□ Nausea	□ Constipation	□ Diarrhea	□ Bad Breath	□ Ulcers
□ Abdominal Pain	□ Vomiting	□ Intestinal Gas	□ Indigestion	□ Rectal Pain
□ Belching	□ Blood in Stools	□ Hemorrhoids	□ Chronic Laxative Use	

Urology

□ Painful Urination	□ Urgency	□ Unable to Hold Urine	□ Decreased Urine Flow	□ Frequent Urination
□ Blood in Urine	□ Cloudy Urine	□ Kidney Stones	□ Pain in Groin Area	
□ Sexually Transmitted Disease		□ Frequent Night Urination		

Neuro-Psychological

□ Seizures	□ Numbness	□ Concussion	□ Twitches	□ Lack of Coordination
□ Depression	□ Irritability	□ Loss of Balance	□ Stress	□ Poor Memory
□ Anxiety	□ Mood Swings	□ Tremors		

Gynecology

□ Irregular Periods	□ Clots	□ Painful Periods	□ PMS	□ Breast Lumps
□ Menopausal	□ Spotting	□ Yeast Infections	□ Vaginal Discharge	□ Fertility Issues

Musculo-Skeletal

□ Arthritis	□ Muscle Weakness	□ Cramping	□ Muscle Spasms	□ Scoliosis
□ Weak Joints	□ Pain with Activity	□ Increased Pain during Hot/ Humid Weather	□ Increased Pain during Cold Weather	

Is there any information that we did not cover on this form that you would like to share?

_____

_____

_____

_____

Name_____ **Date**_____