Feeling Better Together

Balance & Wellness Through Health Care & Community

www.feelingbettertogether.com
Office: 703-626-4326

Name: ____ **Date:** ______________

Age: ________ **Sex:** ________ **Weight:** _________ **Height:** __________ **DOB:** ___________

Known Allergies/Sensitivities:
Environmental: ____
Drug: ____
Food: ____
Alcohol: Yes / No Adhesive: Yes / No Metal: Yes / No

CURRENT HEALTH CONCERNS/MAIN COMPLAINTS (List in order of importance)	Date it began:
1.	
2.	
3.	
4.	
5.	
6.	

LIST ALL CURRENT SUPPLEMENTS/HERBS/MEDICATIONS (& the reason you are taking them):	**PLEASE LIST WESTERN MEDICINE INVESTIGATIONS AND THE RESULTS:** (EX: MRIs, X-Rays, CTs, Endoscopies, Biopsies…)

PLEASE LIST DIAGNOSES RECEIVED TO-DATE:	**Date of Diagnosis:**
1.	
2.	
3.	
4.	
5.	
6.	

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Check all treatment received in the past or being currently received:

- [ ] Bed rest
- [ ] Pharmaceuticals/OTCs
- [ ] Acupuncture
- [ ] Chemotherapy/Radiation
- [ ] Chiropractor
- [ ] Epidural blocks
- [ ] Nerve Blocks
- [ ] Electrical Stimulation
- [ ] Heat Treatment
- [ ] Exercise / Physical Therapy
- [ ] Surgery or Traction
- [ ] Nutrition / Diet Changes
- [ ] Other: ____
- [ ] Substance Abuse

FAMILY HISTORY:

- [ ] Heart Disease
- [ ] Glaucoma
- [ ] Thyroid Condition
- [ ] Hypertension
- [ ] Diabetes
- [ ] Mental Illness
- [ ] Stroke
- [ ] Kidney Disease
- [ ] Bleeding tendencies
- [ ] Cancer
- [ ] Epilepsy
- [ ] Tuberculosis
- [ ] Other: ____

CARDIOVASCULAR:

- [ ] Hypertension
- [ ] Varicose Veins
- [ ] Arrhythmias
- [ ] Hypotension
- [ ] Murmur
- [ ] Congenital Heart Disease
- [ ] Fainting
- [ ] Swelling of Hands/Feet
- [ ] High Cholesterol
- [ ] Palpitation
- [ ] Heart Attack
- [ ] Congestive Heart Failure
- [ ] Chest Pain
- [ ] Angina
- [ ] Rheumatic Fever
- [ ] Pacemaker
- [ ] Excessive Sweating
- [ ] Endo/Peri-Carditis
- [ ] Other: ____________________

RESPIRATORY:

- [ ] Shortness of Breath
- [ ] Asthma
- [ ] Chronic Clearing of the throat
- [ ] Chronic Bronchitis
- [ ] Tuberculosis
- [ ] COPD
- [ ] Cough (acute or chronic)
- [ ] Recurrent Respiratory Infection
- [ ] Sighs/yawns frequently
- [ ] Can't get a satisfying breath
- [ ] Recurrent Sore Throats
- [ ] Other: ____________________

GASTRO-INTESTINAL:

- [ ] Gastric Ulcers
- [ ] Nausea/Vomiting
- [ ] Colitis
- [ ] Diarrhea/Constipation
- [ ] Belching
- [ ] Gall Bladder Disease
- [ ] Gas / Flatulence
- [ ] Hemorrhoids
- [ ] Hepatitis
- [ ] Esophageal Reflux (GERD)
- [ ] Duodenal Ulcers
- [ ] Other: ____________________
- [ ] Bloating/Cramping
- [ ] IBS

ENDOCRINE:

- [ ] Hypothyroidism
- [ ] Diabetes Mellitus:
  Type I: Yes / No
  Type II: Yes / No
- [ ] Always cold feeling
- [ ] Hyperthyroidism
- [ ] Frequent Body Temperature changes
- [ ] Swollen Glands/Lymph Nodes
- [ ] Always hot feeling
- [ ] Unexplained fevers
- [ ] Unexplained Weight: Loss / Gain
- [ ] Other: ____________________

URINARY:

- [ ] Pain with Urination
- [ ] Bladder Disease
- [ ] Dribbling
- [ ] Excessive nighttime urination
- [ ] Kidney Disease
- [ ] Kidney/Bladder Stones
- [ ] Chronic Urinary Tract Infections
- [ ] Irritable Bladder
- [ ] Other: ____________________

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MUSCULO-SKELETAL:

- [ ] Muscle Pain
- [ ] Gout
- [ ] Back Pain
- [ ] Osteoporosis
- [ ] Neck Pain
- [ ] Arthritis
- [ ] Joint Pain
- [ ] Bone Pain
- [ ] Other: ____________________

NEUROLOGICAL:

- [ ] Seizures
- [ ] Neuropathies
- [ ] Stroke/TIA
- [ ] History of Concussion (s)
- [ ] Tremors/Shaking
- [ ] Weakness in Extremities
- [ ] Balance concerns
- [ ] Light-headed
- [ ] Restless Legs
- [ ] Frequent Headaches
- [ ] Limbs "fall asleep" frequently
- [ ] Other: ________________

FEMALE:

- [ ] Pregnancies: #_______
- [ ] Pain during periods
- [ ] Clotting
- [ ] Regular Periods (____ days)
- [ ] Heavy flow
- [ ] Menopausal (_____age)
- [ ] Irregular Periods (____days)
- [ ] Light Flow
- [ ] Other: ________________
- [ ] Loss of sex drive
- [ ] Frequent Yeast Infections
- [ ] Breast Pain
- [ ] Woman's Hormonal Imbalance

MALE:

- [ ] Premature Ejaculation
- [ ] Prostatitis
- [ ] Impotence
- [ ] Loss of Sex Drive
- [ ] Testicular Pain
- [ ] Male Hormonal Imbalance
- [ ] Other: ________________

SKIN/HAIR/NAILS:

- [ ] Poor Skin Integrity
- [ ] Slow wound healing
- [ ] Rashes / Hives
- [ ] Psoriasis
- [ ] Dry Skin/Dandruff
- [ ] Easy to Bruise/Long Lasting Bruises
- [ ] Vitiligo
- [ ] Brittle Nails
- [ ] Eczema
- [ ] Warts
- [ ] Acne (Current or Past)
- [ ] Frequent Skin Eruptions
- [ ] Dry Hair
- [ ] Hair Loss
- [ ] Other: ________________

HEAD/FACE:

- [ ] Vertigo
- [ ] TMJ or Teeth Grinding Concerns
- [ ] Oversensitivity to sounds
- [ ] Facial Numbness or tingling
- [ ] Teeth and Gum Concerns
- [ ] Nose Bleeds
- [ ] Migraines
- [ ] Tongue/Lip Sores
- [ ] Sinusitis
- [ ] Headaches
- [ ] Salivation Concerns
- [ ] Earaches
- [ ] Excessive tearing
- [ ] Excess Mucous
- [ ] Tinnitus/buzzing/ear ringing
- [ ] Cataracts
- [ ] Eye or Mouth Dryness
- [ ] Flashing lights in vision
- [ ] Glaucoma
- [ ] Eye Twitching
- [ ] Other: ________________
- [ ] Photophobia
- [ ] Vision: floaters, blurry, double

PLEASE LIST ALL SURGERIES AND THE RESULTS:

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

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Have you traveled or lived outside of the United States? **Yes / No**
If Yes, where and when?

____
____
____
____
____

Have you worked in a job with exposure to chemicals, high voltage electricity, or other pathogens? **Yes / No**

Do you have any artificial body parts (teeth fillings, breast augmentation, joints, etc.)? **Yes / No**

Did you have the standard childhood vaccines? **Yes / No**

What adult vaccines have you had (flu, shingles, pneumonia, etc.)? ______________________________

Are you aware of any negative reactions to you receiving a vaccine? **Yes / No**

Have you lived in a home with high exposure to mold, high voltage, radiation, etc.? **Yes / No**

PSYCHOLOGICAL/EMOTIONAL:

- ☐ Mood Swings/irritability
- ☐ Depression
- ☐ Disorientation
- ☐ Emotional Hypersensitivity
- ☐ Memory Loss
- ☐ Confusion
- ☐ Brain Fog
- ☐ Anxiety
- ☐ Speech Difficulty (slurred/slow)
- ☐ Difficulty Finding Words
- ☐ Forgets How to Do Simple Tasks
- ☐ OCD / ADD / ADHD
- ☐ Mood Disorders (Bi-polar, etc.)
- ☐ PTSD
- ☐ Frequent use of numbing strategies
- ☐ Feeling like life is too much
- ☐ Past trauma(s)
- ☐ Disconnected from emotions
- ☐ Panic Attacks
- ☐ Difficulty Reading
- ☐ Feels Purposeful in Life
- ☐ Enjoys being with people
- ☐ Eagerly takes on new tasks
- ☐ Other: _________________

HABITS:

- ☐ Smokes: Packs/Day: ___________
  Years smoked: ________________
- ☐ Past Smoker (Stopped ____ years ago)
- ☐ History of drug abuse
- ☐ Uses recreational drugs
- ☐ Coffee: Daily Y / N ____ # cups/day
- ☐ Exercises:
  Type: _________________________
  Frequency: ____________________
- ☐ Current Addictions
- ☐ Drinks Alcohol:
  Daily: Y / N ____ # drinks /day
  Weekly: Y / N ____ # drinks /day
  Type: ___________________
- ☐ Past Addictions

PLEASE LIST HOBBIES AND HOW FREQUENT YOU PURSUE THEM:

	Frequency:
1.	
2.	
3.	
4.	
5.	
6.	

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What factors improve your pain?	What factors make your pain worse?
Does the pain come & go?	Does the pain radiate? To where?
What is the origin of the pain? Or, what can you link the pain to?	

HOW SEVERE IS YOUR PAIN?	**At Rest:**	**1 2 3 4 5 6 7 8 9 10**
(Circle one: 1= no pain, 10-unbearable)	**With Activity:**	**1 2 3 4 5 6 7 8 9 10**

Please use the following pain symbols to describe your pain on the diagrams:

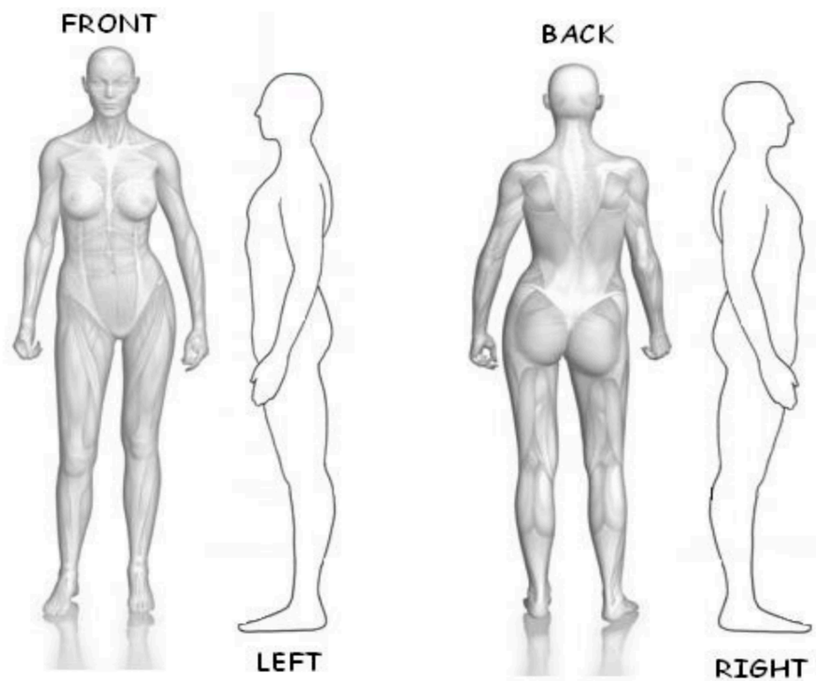
ACHE
>>>>>>>>>>

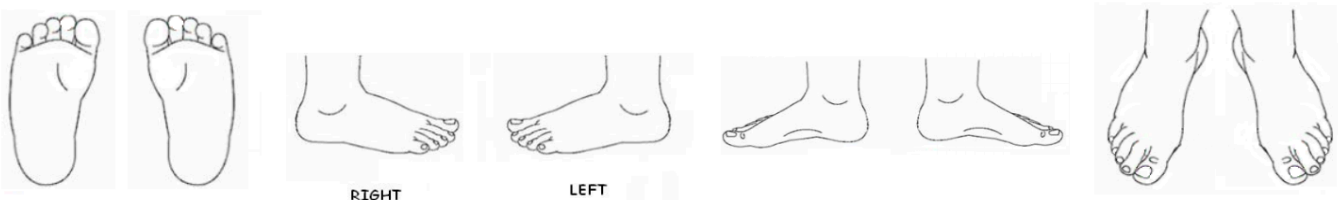
BURNING
XXXXXXXXX

STABBING
///////////

NUMBNESS
OOOOOO

PINS & NEEDLES
****





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SLEEP:

- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Excess Dreams
- ☐ Narcolepsy
- ☐ Sleep Apnea
- ☐ Too much sleep
- ☐ Dream Disturbed Sleep
- ☐ Chronic Fatigue
- ☐ Excessive snoring
- ☐ Low energy levels
- ☐ Talking in Sleep
- ☐ Night Sweats
- ☐ Other: ____

What makes your Chief Complaints better or worse?

Is there anything else you would like us to know about you?

Thank you so much for filling out this intake form so that we may partner with you in your health journey.
Sincerely, Feeling Better Together