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: _____

Metal: Yes / No Adhesive: Yes / No Alcohol (Allergy or Addiction): 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.	

Feeling Better Together
Balance & Wellness Through Health Care & Community

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

NAME: _____

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

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

FAMILY HISTORY:

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Cancer
- ☐ Other: _____
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Thyroid Condition
- ☐ Mental Illness
- ☐ Bleeding tendencies
- ☐ Tuberculosis

CARDIOVASCULAR:

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

RESPIRATORY:

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

GASTRO-INTESTINAL:

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

ENDOCRINE:

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

URINARY:

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

Feeling Better Together
Balance & Wellness Through Health Care & Community

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

NAME: _____

MUSCULO-SKELETAL:

- ☐ Muscle Pain
- ☐ Osteoporosis
- ☐ Joint Pain
- ☐ Gout
- ☐ Neck Pain
- ☐ Bone Pain
- ☐ Back Pain
- ☐ Arthritis
- ☐ Other: _____

NEUROLOGICAL:

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

FEMALE:

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

MALE:

- ☐ Premature Ejaculation
- ☐ Loss of Sex Drive
- ☐ Other: _____
- ☐ Prostatitis
- ☐ Testicular Pain
- ☐ Impotence
- ☐ Male Hormonal Imbalance

SKIN/HAIR/NAILS:

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

HEAD/FACE:

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

PLEASE LIST ALL SURGERIES AND THE RESULTS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

NAME: _____

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.	

NAME: _____

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:

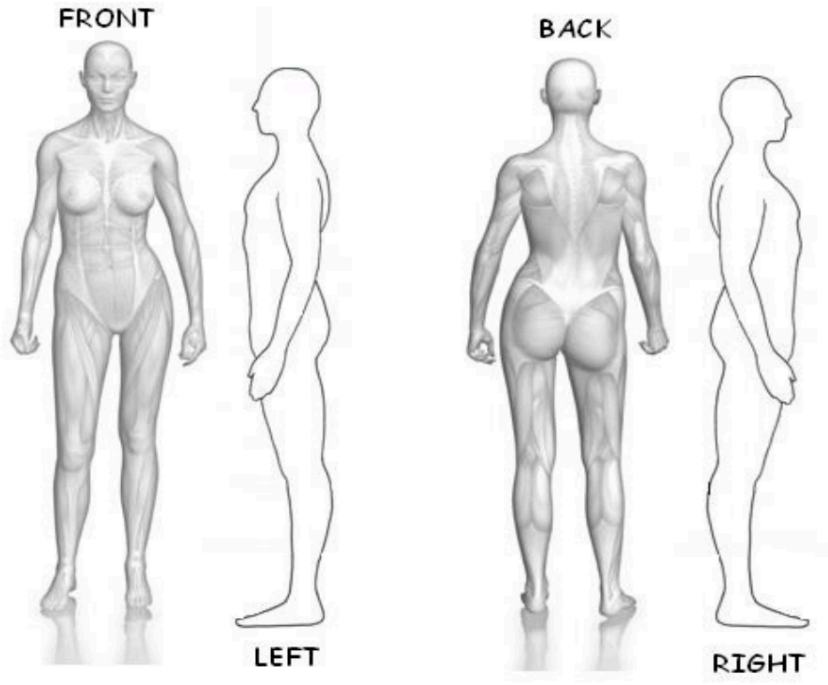
ACHE
>>>>>>>>>>

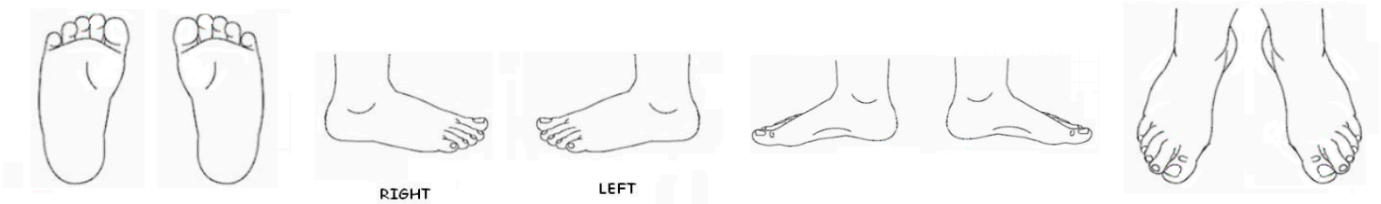
BURNING
XXXXXXXXX

STABBING
//////////

NUMBNESS
OOOOOO

PINS & NEEDLES
****





NAME: _____

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