Welcome to Meadow Hill Wellness

Please note that all information provided is strictly confidential.

First Name: Last Name:

Date of Birth: / /

Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐

Address:

Email Address: Phone:

Emergency Contact: Relationship & Phone:

Family Physician: Phone:

How did you hear about us?

Primary Health Concerns **How long have you had this condition?**

What types of treatments have you tried, if any?

How do these conditions impair your daily activities?

Your Medical History:

Major events in the past ten years and dates they occurred (include births, deaths, marriages, divorce, accidents, major illness, surgery, job changes, miscarriages, and anything else you feel greatly impacted your life or health):

List any medications (prescription and over-the-counter), vitamins, and/or supplements you are currently taking, as well as, medications you have taken in the past:

Name	**Dosage/Frequency**	**How long**	**Reason**

Circle any of the following conditions within your family of origin:

Diabetes, Heart disease, High blood pressure, Stroke, Bleeding/Clotting tendency, Nervous illness, Addiction/Alcoholism, Arthritis, Allergies, Inflammatory bowel disease, Lyme disease, Seizures, Cancer, Gall Stones, Kidney disease or stones, Autoimmune illness, Thyroid problem, Chronic fatigue, Fibromyalgia, Anxiety/Depression, Rheumatic fever, Anemia, Hepatitis, Osteoporosis, Mononucleosis

Any of the above conditions that you have had:

Please list food cravings and dietary restrictions, sensitivities or allergies:

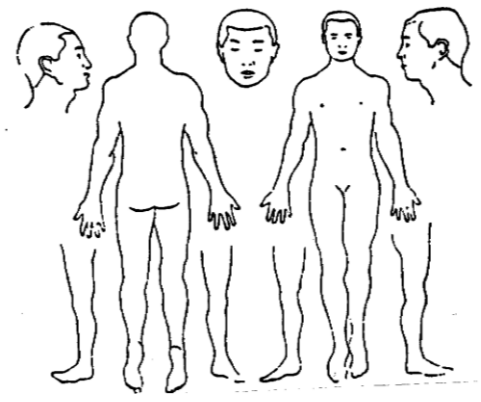
How much pure Water do you intake per day:

Do you Use:	Now	Past	For how long?	Type	Frequency
Tobacco					
Alcohol					
Coffee					
Soft Drinks					
Recreational Drugs					

Do you Exercise? ☐ Yes ☐ No Number of times/ week: _____

Type of exercise:

Please mark all areas of pain on the diagram:



Body Systems Review (please check all that apply):

0 = never **1** = rare **2** = occasional **3** = frequent

0 1 2 3	loose stools	0 1 2 3	heartburn/acid reflux
0 1 2 3	mouth sores	0 1 2 3	fatigue after eating
0 1 2 3	abdominal gas/bloating after food	0 1 2 3	bruise easily
0 1 2 3	gums (bleeding/swollen)	0 1 2 3	thirst
0 1 2 3	organ prolapsed (diagnosed)	0 1 2 3	belching or vomiting
0 1 2 3	spontaneous sweat	0 1 2 3	fatigue
0 1 2 3	allergies	0 1 2 3	catch colds easily
0 1 2 3	asthma	0 1 2 3	shortness of breath
0 1 2 3	general weakness	0 1 2 3	cough
0 1 2 3	dry nose/mouth/skin/throat	0 1 2 3	nasal discharge
0 1 2 3	feel worse after exercise	0 1 2 3	sinus congestion
0 1 2 3	sore, cold or weak knees	0 1 2 3	feel cold
0 1 2 3	low back pain	0 1 2 3	edema
0 1 2 3	frequent urination	0 1 2 3	urinary incontinence
0 1 2 3	early morning diarrhea	0 1 2 3	ear problems
0 1 2 3	muscle spasms/twitches	0 1 2 3	irritable
0 1 2 3	feel better after exercise	0 1 2 3	numb extremities
0 1 2 3	tight feeling in chest	0 1 2 3	dry eyes
0 1 2 3	alternating diarrhea/constipation	0 1 2 3	ear ringing
0 1 2 3	symptoms worse with stress	0 1 2 3	anger easily
0 1 2 3	neck/shoulder tension	0 1 2 3	red eyes
0 1 2 3	feel heart beating	0 1 2 3	chest pain
0 1 2 3	insomnia	0 1 2 3	disturbing dreams
0 1 2 3	sores on tip of tongue	0 1 2 3	headaches
0 1 2 3	anxiety	0 1 2 3	restlessness
0 1 2 3	chest pain traveling to shoulder		
0 1 2 3	see floaters in eyes	0 1 2 3	foggy thinking
0 1 2 3	heat in palms or soles	0 1 2 3	dizzy upon standing
0 1 2 3	feeling of heaviness	0 1 2 3	nausea
0 1 2 3	afternoon fever	0 1 2 3	night sweats
0 1 2 3	enlarged lymph nodes	0 1 2 3	cloudy urine
0 1 2 3	face flushes		

Urination: Please circle any of the following symptoms you are currently experiencing:

Burning Urgent Retention Scanty
Profuse Dribbling Greater than 1x a night

Bowel Movements: Stools: Undigested food Blood Mucus

Frequency: When? _____ Feels complete? □ Yes □ No

Consistency: Well-formed Hard Loose Alternates Undigested food Blood Mucus

Women Only:

At what age did you get your first period: _____ Date of last menstrual cycle? _____

Are you currently on the Pill? □ Yes □ No Are you pregnant now? □ Yes □ No

Number of days from the start of one period to the start of the next: _____

Are your menstrual cycles spaced regularly? □ Yes □ No

Average number of days of flow: _____ Flow is: □ Light □ Normal □ Heavy

Color is: □ Pale □ Normal □ Dark □ Bright Red □ Brown

Are blood clots present? □ Yes □ No

Does your period cause you pain or cramping? □ Yes □ No

Do you experience any of the following before your period each month?

□ Water retention □ Breast tenderness □ Mental depression □ Irritability □ Migraines

Do you ever bleed or spot between periods? □ Yes □ No

Do you have any vaginal discharge between periods? □ Yes □ No

Do you have chronic vaginal discharge? □ Yes □ No

Date of last pap smear? _____

Have you ever been diagnosed with endometriosis or fibroids? □ Yes □ No

Have you experienced menopause? □ Yes □ No When? _____

Symptoms associated with menopause : _____

Pregnancies (please include losses and terminations):

Year Vaginal or C section Complications or conditions of note

_____

_____

_____

Men Only:

Have you been diagnosed with prostate problems? □ Yes □ No

Have you ever experienced Low Libido? □ Yes □ No

Additional things you'd like to mention related to health or well-being not previously covered:

Thank you for taking the time to fill out this form thoroughly.
It will help us serve you better.

Signature: _____ Date:_____