Wisdom Health Center

~Whole Body Healing~

Welcome to Innate Wisdom Health. Please fill out all of the information before your visit and bring it with you to your first appointment. We look forward to meeting you!

Clinical Intake & Health History

Date_____ Name _____
Complete Address _____
Email _____Age ____DOB_____
Birthplace and time: _____Is this where you grew up?_____
Marital Status _____Name of Spouse _____
Phone—cell, work, home _____
Employer _____ Occupation _____
Height _____Weight _____ Has your weight recently changed? _____
Emergency Contact _____ Phone _____
How were you referred to this office and why? _____

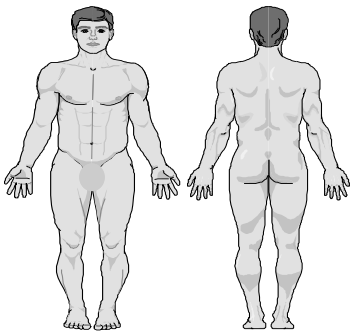
List your present complaint or why you are seeking care and when you first noticed the problems:

Is it getting better or worse? Does anything make it feel better or worse?

Is there a specific time of day/month/year that it is better or worse?

Which activities are difficult to perform (mark all that apply)?
Lying down *Sitting* *Standing* *Walking* *Exercise* *Bending* *Other* _____

Please list on the drawing below the area & type of pain you are experiencing AND the location of scars or surgery:
S-Sharp D-Dull T-Throbbing N-Numbness
A-Aching SH-Shooting B-Burning T-Tingling
C-Cramping SW-Swelling ST-Stiffness



What other methods have you tried in the past and did it help?

How would you describe your overall state of health?
Excellent Good Fair Poor Constantly changing

From whom and for what purpose are you currently seeking any additional health care providers?
Name Phone Diagnosis/Reason for Seeking Care
_____
_____
_____
_____

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Please list any recent procedures and the date:

Test	Year	Test	Year	Test	Year	Other Tests
☐Chest X-ray	_____	☐TB Test	_____	☐Pap Smear	_____	_____
☐Kidney X-Ray	_____	☐EKG	_____	☐Mammogram	_____	_____
☐G.I. Series	_____	☐CAT Scan	_____	☐Sigmoidosopy	_____	_____
☐Spine Series	_____	☐MRI	_____	☐Rectal Exam	_____	_____
☐Blood Tests	_____	☐Cardiac Stress	_____	☐Physical Exam	_____	_____
☐Colon X-ray	_____	☐Cholesterol	_____	☐PSA	_____	_____

Please mark all that apply to you:

Never	Previously	Presently		Never	Previously	Presently		Never	Previously	Presently	
☐	☐	☐	Aids/HIV	☐	☐	☐	Epilepsy	☐	☐	☐	Rheumatic fever
☐	☐	☐	Alcoholism or chemical dependency	☐	☐	☐	Fractures	☐	☐	☐	Scarlet Fever
				☐	☐	☐	Glaucoma	☐	☐	☐	Stroke
☐	☐	☐	Allergy Shots	☐	☐	☐	Goiter	☐	☐	☐	Suicide Attempt
☐	☐	☐	Allergies: Food	☐	☐	☐	Gout	☐	☐	☐	Thyroid Problem
☐	☐	☐	Allergies: Environment	☐	☐	☐	Headaches	☐	☐	☐	Tonsillitis
☐	☐	☐	Allergies: Medications	☐	☐	☐	Heart Disease	☐	☐	☐	Tuberculosis
☐	☐	☐	Anemia	☐	☐	☐	Hepatitis	☐	☐	☐	Tumors
☐	☐	☐	Anorexia	☐	☐	☐	Hernia	☐	☐	☐	Growths
☐	☐	☐	Appendicitis	☐	☐	☐	Herniated Disc	☐	☐	☐	Typhoid Fever
☐	☐	☐	Arthritis	☐	☐	☐	Herpes	☐	☐	☐	Ulcers
☐	☐	☐	Asthma	☐	☐	☐	Kidney Disease	☐	☐	☐	Vaginal Infections
☐	☐	☐	Bleeding Disorders	☐	☐	☐	Liver Disease	☐	☐	☐	Venereal Disease
☐	☐	☐	Bloating	☐	☐	☐	Measles	☐	☐	☐	Whopping Cough
☐	☐	☐	Breast Lump	☐	☐	☐	Migraines	☐	☐	☐	Feel cold often
☐	☐	☐	Bronchitis	☐	☐	☐	Miscarriage	☐	☐	☐	Dislike the cold
☐	☐	☐	Bulimia	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	Feel hot often
☐	☐	☐	Cancer	☐	☐	☐	Mumps	☐	☐	☐	Dislike heat
☐	☐	☐	Candida overgrowth	☐	☐	☐	Osteoporosis	☐	☐	☐	Afternoon flush/fever
☐	☐	☐	Cataracts	☐	☐	☐	Parkinson's	☐	☐	☐	Night or day sweats
☐	☐	☐	Chicken Pox	☐	☐	☐	Pneumonia	☐	☐	☐	Hot palms or soles
☐	☐	☐	Depression	☐	☐	☐	Polio	☐	☐	☐	Tend to constipation
☐	☐	☐	Diabetes	☐	☐	☐	Prostate Problems	☐	☐	☐	Tend to loose stools
☐	☐	☐	Dizziness	☐	☐	☐	Psychiatric Care				
☐	☐	☐	Emphysema	☐	☐	☐	Rheumatoid Arthritis				

List major events of your health history that is not listed above (illness, specific diagnosis, surgery/ hospitalization, accidents, toxin or heavy metal exposure, deaths, pregnancies, mental health care, etc and your age at the time):

Please list any allergies or sensitivities and typical reaction:

Please list any significant family health history and their relation to you:

Any excess or unresolved emotional patterns?

Other Health History

Please list all medications, prescriptions, birth control, recreational drugs or supplements you are currently taking along with the duration of use, dosage amount and for what purpose (use the back if you need additional room):

Antibiotic history—estimate the total number of times you have used antibiotics, and the duration (i.e., if you used 7 times in your life for 2 weeks then the total number would be 98 times). Also explain in extended use such as for acne:

Do you have root canals? _____ If so, how many? _____ Do you have dental amalgams? _____
Do you have any other dental problems or history? _____

Were you breast fed? _____ If so, for approx. how many months? _____

Have you been immunized? _____ Please list all immunizations and dates:
_____
_____
_____
_____
_____
_____

Have you traveled abroad? _____ Where and when? _____
_____

Do you currently or have you ever had pets in your house? _____
_____

Do you use a Bluetooth? _____ Put a cell phone to your head when talking? _____
Do you have wireless networking at home or in your office? _____
How many hours per week do you spend on the computer? _____ Is it a laptop? _____

Do you fly often? _____ How many times a year? _____

Please describe any toxin or chemical exposure at work, or in your life:
_____
_____
_____

Lifestyle

How committed are you to doing whatever it takes in your diet and lifestyle to improve your health? (0=not at all, 10=100% ready and committed to make any changes necessary in order to improve my health)

0 1 2 3 4 5 6 7 8 9 10

Please check all statement (s) that apply to you.

_____ I am nervous about making any drastic nutritional/lifestyle changes at this time.

_____ I am seeking primarily symptom relief, and not interested in making lifestyle/dietary changes.

_____ Right now I am gathering as much information as possible about my health in order to make a decsion about how I want to achieve my health goals.

_____ I can foresee taking smaller steps with changes along the way to achieve my health goals.

_____ I am looking for more of a wellness-type approach or treatment plan. I am motivated to make nutritional/lifestyle changes to benefit my health immediately. I am committed to my health.

_____ In _____days/months, I will begin to make changes to my diet/lifestyle in order to benefit my health.

_____ In the last ____ months/yrs. I have been making changes in my eating habits based on nutritional information I have read or received from a health-care practitioner.

_____ In the past, I have made changes to my diet, but I found that it was very difficult to adjust, or maintain those changes in my life.

What are the pros/cons of changing your diet, lifestyle and daily habits?

Given a 24hr day, how many hours do you sleep? _____Is it enough? _____
Do you sleep through the night? _____
What time do you get out of bed each day? _____
How do you feel upon awaking from sleep? _____
When do you experience energy slumps?_____
When do you feel most alert, and function at your best?_____

What kind of activities do you do and how often (i.e. running, hiking, yoga, etc)

_____
_____
_____

What do you do to replenish yourself mentally, emotionally, physically and spiritually?

Diet

Do you eat any of the following:
_____Dairy: ___Milk ___Raw milk ___Goat's milk ___Cheese ___Yogurt _Other _____
_____
_____Wheat: ___Bread ___Pasta ___Tortilla ___Baked goods ___Cereals _Other _____
_____
_____Soy: ___Tofu ___Soy Sauce ___Miso ___Soy Milk ___Soy protein ___Edamame ___Other ___
_____
_____Corn: ___Cornmeal ___High-fructose corn syrup ___Corn chips/tortilla _Other _____
_____
_____Sugar: ___Candy ___Cakes/pies ___Desserts ___Ice cream ___Honey or Agave
Other_____
_____Protein shakes: ___Soy ___Whey ___Egg ___Pea ___Hemp __Other_____
_____
_____Processed food: ___Canned food _____Cold cereals _____Processed meats ___Frozen foods
_Other_____
___Vegetables_____
___Fruit_____
___Grains_____
___Legumes_____
___Protein_____
___Other_____
Please describe your typical breakfast, what you eat, when and how:

Please describe your typical lunch, what you eat, when and how:

Please describe your typical dinner, what you eat, when and how:

Please describe your snacks, what you eat, when and how:

Do you drink caffeine? _____ If so, how much and what? _____
Do you drink diet drinks? _____If so, how much and what? _____
Do you drink alcohol? _____ If so, how much and what? _____
How much water do you drink? _____What kind?_____

Describe your relationship with food:_____
_____
Why do you think it is the way it is?_____
What do you need to do first in order to change it?_____
How do you use food in your life?_____
What foods do you crave?_____
Why do you think you crave them?_____
Is there any food I should not ask you to eliminate?_____
Do you have any food restrictions?_____
What foods do you not like?_____

Please rate your level of comfort in cooking or being in the kitchen (0=not so much, 10=expert chef)

0 1 2 3 4 5 6 7 8 9 10

Please rate your willingness to learn, try and increase your contact with preparing food:

0 1 2 3 4 5 6 7 8 9 10

Other Lifestyle Considerations

What or who inspires you?

Do you meditate or have a daily reflection practice?

Do you retain your dreams?

What is your experience or knowledge of energy, chi/qi, tao, energetics, etc?

What is your commitment to yourself at this time (and perhaps moving forward)?

Do you experience stagnation, blocks or repeating patterns that will not change? If so, please explain.

Please rate your current status for the following: (1=poor, 10=blissful)

Mental well being 0 1 2 3 4 5 6 7 8 9 10
Physical well being 0 1 2 3 4 5 6 7 8 9 10
Emotional well being 0 1 2 3 4 5 6 7 8 9 10
Spiritual well being 0 1 2 3 4 5 6 7 8 9 10
Integration or Harmonization of all the above: 0 1 2 3 4 5 6 7 8 9 10

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative_____ Date_____