VITAL HEALTH AND WELLNESS

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Name_______________________________ Date_______________________________

Address ____

City_______________________ State__________ Zip code__________

Phone (hm)______________ (wk) ______________ E-mail______________________

Age________ Date of birth ________________ Gender: female male

Place of birth: ____

Employer____

Please circle what best applies to you:

Married Partnership Single Separated Divorced Widowed

Live with: Spouse or partner Parents Children Friends Alone

Next of kin or other to reach in case of emergency: _____________________________

Relationship_____________________ Phone_____________________________

Address____

How did you hear about Dr. Jackson? (ie: Internet, Friend, HealthFair?)
____

Can Dr. Jackson send you appointment reminders via email: Yes No

CONTEXT OF CARE REVIEW

Why did you choose this clinic?

What do you know about our approach to your healthcare?

What *three* expectations do you have from your *first visit* to this clinic?

What are your *long-term goals* in working with this clinic?

What is your present level of commitment to address any underlying causes of your signs and
Symptoms that relate to your lifestyle? Please circle a Rating from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe negatively impact your health and wellbeing?

What potential obstacles do you foresee in addressing any lifestyle factors that may be undermining your health or adhering to the therapeutic protocols we will be sharing with you?

What do you love to do?

Rate your level of fulfillment in the following areas of your life. 0=no fulfillment/10=great fulfillment

Career	1	2	3	4	5	6	7	8	9	10
Money	1	2	3	4	5	6	7	8	9	10
Health	1	2	3	4	5	6	7	8	9	10
Relationship	1	2	3	4	5	6	7	8	9	10
Fun & Recreation	1	2	3	4	5	6	7	8	9	10
Family & Friends	1	2	3	4	5	6	7	8	9	10
Friends	1	2	3	4	5	6	7	8	9	10
Physical	1	2	3	4	5	6	7	8	9	10
Environment	1	2	3	4	5	6	7	8	9	10

Are you currently receiving healthcare? Y N

If yes, from whom?______________________________

If no, when and where did you last receive medical or healthcare? ______________________________

What was the reason? ______________________________

What are your most important health problems? List as many as you can in order of importance:

(1) ______________________________
(2) ______________________________
(3) ______________________________
(4) ______________________________
(5) ______________________________
(6) ______________________________
(7) ______________________________

Do you have any known contagious diseases at this time? Y N
If yes, what? ______________________________

FAMILY HISTORY
Consider the following conditions and your family history. (**MGM**= maternal grandmother, **MGF**= maternal grandfather, **PGM**= paternal grandmother, **PGF**= paternal grandfather)

Cancer Diabetes Heart Disease High Blood Pressure Kidney disease Epilepsy
Arthritis Glaucoma Tuberculosis Stroke Anemia Mental Illness
Asthma Hay fever Autoimmune Disease Thyroid problems Addiction

Please indicate who in your family has the condition and the age of onset of their condition.
Mom ____________________

Dad ____________________

Sister ____________________

Brother ____________________

Aunt ____________________

Uncle ____________________

MGM ____________________

MGF ____________________

PGM ____________________

PGF ____________________

Any other relevant family history? ____________________

What is your family heritage? ____________________

CHILDHOOD ILLNESSES
Please circle whether you had any of the following as a child:

Rheumatic Fever Diphtheria Scarlet Fever Chicken pox

German Measles Measles Mumps

HOSPITALIZATION AND SURGERY
What hospitalizations and surgeries have you had?

____________________year:__________ ____________________year:__________
____________________year:__________ ____________________year:__________
____________________year:__________ ____________________year:__________

IMMUNIZATIONS
Polio Y N
Tetanus shot Y N
Measles/Mumps/Rubella Y N
Pertussis Y N
Diphtheria Y N
Other____________________

ALLERGIES
Are you hypersensitive or allergic to:
Any drugs? ____________________
Any foods? ____________________
Any chemicals? ____________________

CURRENT MEDICATIONS AND SUPPLEMENTS
Please list **any** prescription medications, over-the-counter medications, vitamins, or other supplements you are taking:

Name	Dose	Purpose	Who Prescribed it? (ie- MD, self, ND)	Duration of usage.

(1) ______________________________
(2) ______________________________
(3) ______________________________
(4) ______________________________
(5) ______________ ______________
(6) ______________________________
(7) ______________________________
(8) ______________________________
(9) ______________________________
(10) ______________________________

TYPICAL FOOD INTAKE
Breakfast: ______________________________
Lunch: ______________________________
Dinner: ______________________________
Snacks: ______________________________
To drink: ______________________________
Do you strongly desire any particular foods?
____
Do you strongly dislike any particular foods?
____
Are there any foods that make you feel bad or aggravate any of your symptoms?
____

FOR THE FOLLOWING, PLEASE CIRCLE
Y=a condition you **have now**; **N**=**never had**; **P**=a condition you **have had** before

HABITS
Main interests and hobbies?
____
Do you exercise? Y N
If yes, what kind and how often? ______________________________
Do you currently have a supportive relationship? Y N
Have a history of abuse? Y N If yes, did you receive counseling? Y N
Any major traumas? Y N P
Do you currently use tobacco? Y N If yes, how many packs/day? ________
Smoked previously? Y N P How many years? ________ What age did you quit? ________
How many packs per day? ________
Have you been treated for drug dependence? Y N P
Do you use alcoholic beverages? Y N P If yes, how many drinks/week? ________

Have you been treated for alcoholism? Y N P
Enjoy your work? Y N
Do you spend time outside everyday? Y N
Do you have a religious or spiritual practice? Y N P
Watch television? Y N If yes, how many hours/day? ___________________
Take vacations? Y N

ENDOCRINE

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Thirstless?	Y N P	Fatigue?	Y N P

IMMUNE

Vaccinations?	Y N P	Reactions to vaccinations?	Y N P
Chronic Fatigue Syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

NEUROLOGIC

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Loss of balance?	Y N P
Vertigo or Dizziness?	Y N P		

SKIN

Rashes?	Y N P	Eczema, hives?	Y N P
Acne, boils?	Y N P	Itching?	Y N P

HEAD

Headaches?	Y N P	Head injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems?	Y N P
Hair loss?	Y N P	Dandruff?	Y N P

FACE

Pain/neuralgia?	Y N P
Acne?	Y N P
Twitching?	Y N P

EYES

Spots in eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain, strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double vision?	Y N P	Glaucoma?	Y N P
Aversion to sun?	Y N P	Itchy eyes?	Y N P
Redness?	Y N P	Sties?	Y N P

EARS

Impaired hearing?	Y N P	Ringing/noises in ears?	Y N P
Earaches?	Y N P	Chronic ear infections?	Y N P
Discharge from ears?	Y N P	Itching in ears?	Y N P

NOSE AND SINUSES

Frequent colds?	Y N P	Nose bleeds?	Y N P
Stuffiness?	Y N P	Hayfever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

NOSE AND SINUSES (con't)

Breathing problems?	Y N P	Frequent sneezing?	Y N P
Eruptions, sores?	Y N P		

MOUTH AND THROAT

Frequent sore throat?	Y N P	Bad breath?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Loss of teeth?	Y N P	Hoarseness?	Y N P
Gum problems?	Y N P	Jaw clicks?	Y N P
Dental cavities?	Y N P	Canker sores?	Y N P
Fever blisters?	Y N P	Cracked lips?	Y N P
Tooth sensitivity?	Y N P	Cracks on tongue?	Y N P
Loss of taste?	Y N P		

NECK

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P
Choking feeling?	Y N P		

RESPIRATORY

Cough?	Y N P	Spitting up mucus?	Y N P
Spitting up blood?	Y N P	Wheezing?	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing walking	Y N P
Pain breathing?	Y N P	Difficulty breathing lying down	Y N P
Climbing stairs difficult	Y N P		
Persistent hoarseness?	Y N P		

CARDIOVASCULAR

Heart disease?	Y N P	Chest pain at rest?	Y N P
High/Low Blood Pressure	Y N P	Chest pain with exertion?	Y N P
Blood clots?	Y N P	Leg pain unrelated to injury?	Y N P
Fainting?	Y N P	Easy bruising or bleeding?	Y N P
Ankle or leg swelling?	Y N P	Phlebitis?	Y N P
Rheumatic Fever?	Y N P		

GASTROINTESTINAL

Bowel movements: How often? ____________		Bloating?	Y N P
Heartburn?	Y N P	Belching?	Y N P
Frequent nausea?	Y N P	Flatulence/passing gas	Y N P
Frequent vomiting	Y N P	Hurried eating?	Y N P
Diarrhea?	Y N P	Difficulty swallowing?	Y N P
Constipation?	Y N P	Bloody stools?	Y N P
Abdominal/stomach pain?	Y N P	Hemorrhoids?	Y N P
Light colored stools?	Y N P	Ulcer?	Y N P
Rectal pain?	Y N P	Gall bladder disease?	Y N P
Rectal itching?	Y N P		

URINARY

Frequent urination?	Y N P	Strong smelling urine?	Y N P
Frequency at night?	Y N P	Frequent infections?	Y N P
Painful urination?	Y N P	Blood in urine?	Y N P
Difficult urination?	Y N P	Involuntary urination?	Y N P

MALE SYMPTOMS

Hernias?	Y N P	Discharge or sores?	Y N P

Testicular pain? Y N P
Venereal disease? Y N P
Infertility? Y N P
Sexually Transmitted Infection? Y N P

Difficult or loss of erection? Y N P
Painful erections? Y N P
Lump, swelling, or masses in testicles? Y N P
Prostate disease? Y N P

FEMALE SYMPTOMS

Age of first menses? ___________
Age of last menses (if menopausal)? _______
Date of Last Menses: _____________
Length of cycle : __________days
Duration of menses? _______days
Are cycles regular? Y N
Bleeding between cycles? Y N P
Heavy or excessive flow? Y N P
PMS? Y N P
Date of Last Pap? ___________
Abnormal PAPS? Y N P
If yes, date of last abnormal Pap? _________
Number of pregnancies? ________
Number of live births? __________
Number of miscarriages? ________
Number of abortions? __________
Sexually Transmitted Infection? Y N P
Birth Control Pills or Hormones? Y N P
Menopausal symptoms? Y N P If yes, please list: ____

Vaginal itching? Y N P
Vaginal dryness? Y N P
Vaginal infections? Y N P
Ovarian cysts? Y N P
Uterine fibroids? Y N P
Sexual difficulties? Y N P
Painful intercourse? Y N P
Difficulty conceiving? Y N P
History of sexual abuse? Y N
Endometriosis? Y N P
Swelling or lumps in breast? Y N P
Painful breasts? Y N P
Nipple discharges? Y N P

PERSPIRATION

Excessive sweating? Y N P If yes, Specify part of body ___________________
Night sweats? Y N P
Strong odor of perspiration? Y N P

SLEEP

Difficulty falling asleep? Y N P
Interrupted sleep? Y N P
Feeling on waking in morning? ____________
Favorite sleep position? __________________
Sleep walking? Y N P
Number of hours per night? _______________

MUSCULOSKELETAL

Pain?	Y N P	Coldness?	Y N P
Stiffness?	Y N P	Twitching?	Y N P
Swelling?	Y N P	Tremors?	Y N P
Numbness?	Y N P	Weakness?	Y N P
Tightness?	Y N P	Paralysis?	Y N P
Burning/heat?	Y N P	Shooting pains?	Y N P

Thank you for your time and effort in filling out this paperwork. I look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so in the following space or on the page of this page: