RAPHA
holistic wellness

Personal Information

Name: Age: Date of Birth:

Nickname or Preferred Name: Marital Status: Single ☐ Divorced ☐

Married ☐ Widowed ☐

Home/Mailing Address: Other ☐

City: State: Zip:

Telephone: ( )

Email Address:

Occupation: Employer:

Emergency Contact: Relationship:

Telephone: ( ) Email:

Most of our clients are referred to us by a caring family member or friend. Whom may we thank for referring you to our office? Or how Did you hear about us?

Health Information

Health Concerns: Please list your top health concerns or complaints that you would like to address (in order of priority):

1)

2)

3)

Are these concerns affecting your quality of life? (Please chek all that apply)

	Yes	No		Yes	No
Work/School:	☐	☐	Sleep:	☐	☐
Eating:	☐	☐	Sitting:	☐	☐
Recreation:	☐	☐	Exercise/Sports:	☐	☐
Walking:	☐	☐	Intimate/Personal Life:	☐	☐

General Information

Height: Weight: Recent Weight Loss ☐ Amount: LBS

Recent Weight Gain ☐ Amount: LBS

Reason/Method for Weight Loss/Gain: Number of Bowel Movements per Day

	Yes	No		Yes	No
Difficulty falling asleep?	☐	☐	Lightheaded/irritable when hungry?	☐	☐
Difficulty staying asleep?	☐	☐	Crave sugar/salt?	☐	☐
Tired after full nights sleep?	☐	☐	Need coffee/sweets 3-5PM?	☐	☐
Fatigue after meals?	☐	☐	Do you eat breakfast?	☐	☐
			Do you eat snacks?	☐	☐

What time do you eat Breakfast? Usual breakfast foods:

What time do you eat Lunch? Usual lunch foods:

What time do you eat Dinner? Usual dinner foods:

What times to you eat Snacks? Usual snacks:

Do you have any dietary restrictions? Please explain (vegetarian, gluten/dairy intolerance, Kosher etc.)

Allergies/Sensitivities:

Please check and list all allergies/sensitivities

Food: ☐ Gluten: ☐ Soy: ☐ Dairy: ☐ Nuts: ☐ Other:

Medicaitions:

Seasonal/Latex/Other:

Have you taken oral steroids (Cortisone, Prednisone) If yes:

As a child did you have a restricted diet, or were you allergic to any foods? If yes:

Habits:

Please inclue current and previous amounts

	Daily	Weekly	Monthly	Never	Amount
Alcohol	☐	☐	☐	☐	_____
Coffee	☐	☐	☐	☐	_____
Soda/Diet Soda	☐	☐	☐	☐	_____
Tobacco	☐	☐	☐	☐	_____
Recreational Drugs	☐	☐	☐	☐	_____

**If you no longer consume the above, please note length of consuption and date stopped.*

	5-7x/Week	3-5x/Week	1-3x/Week	None	
Exercise	☐	☐	☐	☐	
	8+ Hours	7-8 Hours	6-7 Hours	5-6 Hours	<5 Hours
Sleep	☐	☐	☐	☐	☐
	5+	4	3	2	1
Meals/Day	☐	☐	☐	☐	☐
	8+ Cups	4-7 Cups	2-4 Cups	<8 Oz	
Water/Day	☐	☐	☐	☐	

How many times a week do you eat out?

Work Activity:

Heavy Labor	☐	Mostly Standing	☐
Light Labor	☐	Walking/Moving	☐
Mostly Sitting	☐	Driving	☐

Stress Level:

Very High	☐
High	☐
Medium	☐
Low	☐

Medical History:

☐ Abdominal Pain	☐ Fullness of Bladder	☐ Shoulder Pain
☐ Ankle/Foot Pain	☐ Headache	☐ Sinusitis
☐ Blurred Vision	☐ Hemorrhoids	☐ Slow Heart Rate
☐ Chest Pressure	☐ High Blood Pressure	☐ Sore Muscles
☐ Clammy Hands	☐ Hip Pain	☐ Sore Throat
☐ Confusion	☐ Insomnia	☐ Swallowing Pain
☐ Constipation	☐ Irritabiity	☐ Sweating
☐ Convulsions	☐ Joint Stiffness	☐ Sollwen Joints
☐ Decreased Sex Drive	☐ Knee Pain	☐ Teeth Grinding
☐ Dizziness	☐ Low Back Pain	☐ Tingling in Feet
☐ Dry Mouth	☐ Low Blood Pressure	☐ Tingling in Hands
☐ Earache	☐ Lump in Throat	☐ Unusual Lumps
☐ Elbow Hand Pain	☐ Mensrual Irregulations	☐ Urination Difficulty
☐ Excessive Thrist	☐ Nausea/Vomiting	☐ Walking Problems
☐ Eye Pain	☐ Neck Pain	☐ Weak Muscles
☐ Facial Pain	☐ Paralysis	☐ Other
☐ Fainting	☐ Persistent Cough	_____
☐ Fatigue	☐ Poor Appetite	_____
☐ Feel Loss of Control	☐ Poor Circulation	_____
☐ Forgetfulness	☐ Rapid Heart Rate	_____
☐ Frequent Urination	☐ Shakiness	_____

Are you currently under the care of any other provider(s)? (MD, Dentist, Psychologist, please list condition or general care etc.)

	Yes	No
Date of most recent physical or annual exam: _____ Did you have blood work?	☐	☐

Results/Concerns:

Women Only:

	Yes	No
Is there any chance you might be pregnant?	☐	☐
Are you experiencing perrimenopause?	☐	☐
Reached Menopause?	☐	☐
Are you experiencing symptoms?	☐	☐

Date of last metrual cycle: _____

Accidents:

Have you been involved in any of the following types of accidennts? (Check all that apply.)

☐ Automobile	☐ Sports	☐ Other
☐ Motorcycle	☐ Playground	
☐ Bicycle	☐ Abuse	

Year (approximate)	Please describe (injuries,, treatment, outcome)

Injuries:

Have you ever injured any of the following regions? (Check all that apply.)

- ☐ Head
- ☐ Neck
- ☐ Rib/Chest
- ☐ Back
- ☐ Pelvis/Hip
- ☐ Arm/Hand

Year (approximate)	Please describe (injuries,, treatment, outcome)

Serious Illness/Hospitalizations/Surgeries:

Please detail hospitalizations/serious illnesses/surgeries

Year (approximate)	Reason	Outcome

Medications:

Please list all medications you are currently or have recently taken (prescribed or over-the-counter)

Medication Name	Condition	Date Started	Prescribed by?

Nutritional Supplements:

Please list all Vitamins and Nutritional Supplements you are currently or have recently taken

Supplement	Brand & Amount Consumed	Date Started	Prescribed by? (if applicable)

Previous Medication History: Please list an approximate number of times you have taken antibiotics for illnesses, yeast infections, skin disorders (including acne), dental procedures, surgery etc.

	Yes	No
Have you ever been on a long term antibiotic (1 month or more) or Intravenous (IV)?	☐	☐
Have you ever taken Probiotics?	☐	☐

Additional Notes: