INTEGRATIVE WELLNESS
Center for Healthcare and Education

132 Great Rd
Stow, MA 01775
978-461-2001

Please take the time to fill out this questionnaire carefully They are important in us working together to achieve your health goals. All of your answers are held absolutely confidential.

Today's Date:

Name (First & Last)	Home Phone ( ) -	Work/Cell Phone ( ) -
Street	City	State/Zip

Email	Date of Birth	Age	Height	Weight

Occupation	PCP Physician	Who can we thank for the referral?

Emergency Contact (Name & Relation to you)	Emergency Phone( ) -

What is the main problem(s) you'd like to address? 1. 2. 3. 4.
How long ago did this problem begin?
To what extent does this problem interfere with your daily activities such as work, sleep, sex?
Have you been given a diagnosis for this problem? If so, what?
What other kinds of treatments have you tried?

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Medical History:

Check all conditions you've had in the past or currently have:

☐Diabetes	☐Allergies	☐Glaucoma	☐Rheumatic Fever
☐Heart Disease	☐CVA (stroke)	☐Vein condition	☐Thyroid disorder
☐Asthma	☐Pneumonia	☐Tuberculosis	☐Emphysema
☐Jaundice	☐Gonorrhea	☐Mumps	☐Bleeding tendency
☐Syphilis	☐Measles	☐Chicken pox	☐Nervous disorder
☐Meningitis	☐HIV	☐Polio	☐Mononucleosis
☐Epilepsy	☐High fever	☐Hepatitis _____	☐Multiple Sclerosis
☐Eczema/Psoriasis	☐Migraines	☐High blood pressure	☐Paralysis
☐other lung illnesses	☐other liver illnesses	☐Gallstones	☐Kidney Stones
☐Cancer	☐Hemorrhoids	☐other__________________	

Have you ever been on long term antibiotic therapy (more than 2 weeks?)

Surgeries (type and date)

Significant Trauma (auto accidents, falls, abuse etc)

Significant Dental Work (type and date)

Allergies (pollen, dander, drugs, synthetic chemicals, foods)

Family Medical History (check and include relation to you)

☐Asthma	☐Heart Disease	☐High Blood Pressure
☐Stroke	☐Seizures	☐Thyroid
☐Diabetes	☐Cancer(type)	☐Other

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Present Medical History

Prescription, OTC or vitamin/mineral/supplements/herbs taken within past 3 months:

☐Antacids	☐Antibiotics	☐Anticonvulsants	☐Antidepressents
☐Antianxiety meds	☐Aspirin/Ibuprofen	☐Asthma inhalers	☐Beta blockers
☐Birth control pills/implants	☐Chemotherapy	☐Cholesterol lowering meds	☐Cortisone/steroids
☐Diabetic medications/insulin	☐Diuretics	☐Hormone replacement	☐Heart Meds
☐High blood pressure meds	☐Laxatives	☐Recreational drugs	☐Relaxants/Sleeping pills
☐Thyroid meds	☐Acetaminophen (Tylenol)	☐Ulcer meds	

Do you know your Blood Type: (if so what is it?):

Medication and Supplements	Dosage	Reason for Taking

Do you have a regular exercise program? ☐Yes (please describe) ☐No

How many colds do you get per year? _______
Describe:

Do you feel like you are under much stress? ☐Yes (please describe) ☐No

Sleep: Hours/Night_____ What time do you retire to bed?_____ What time do you wake?____
Do you feel rested when you wake up? ☐Yes ☐No
Do you sleep through the night? ☐Yes ☐No ____________________________________
Please add any other comments about your sleep or sleep history:

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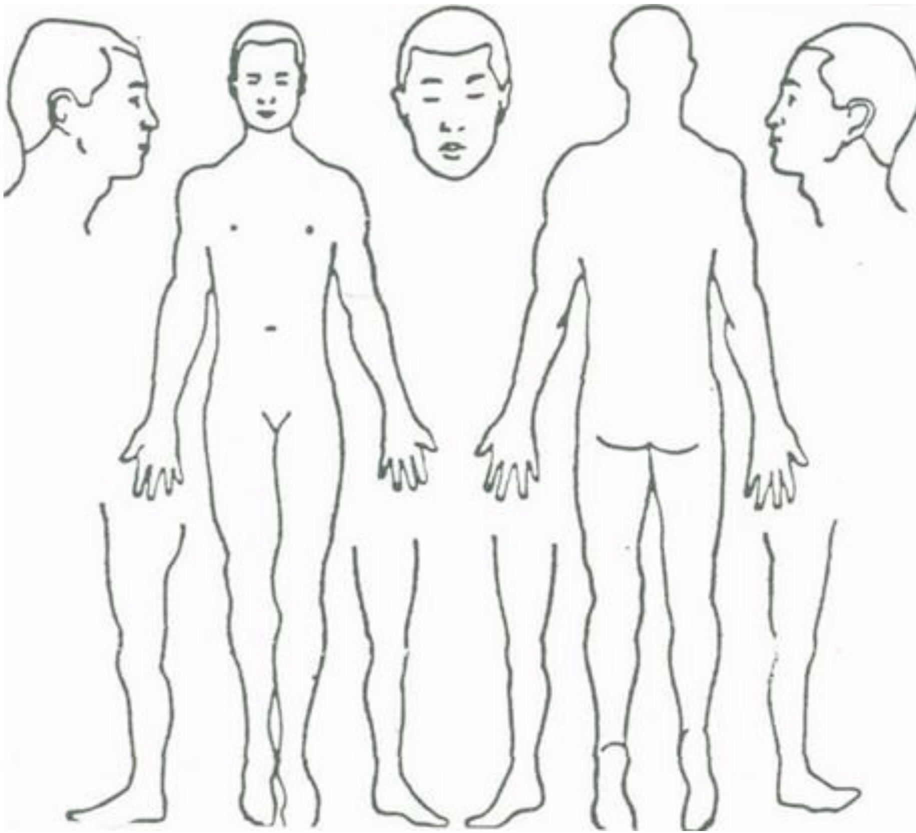
Indicate Painful or Distressed Areas



Please add any additional comments about musculoskeletal issues:

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Women only GYN

Regular menstrual cycle? ☐No ☐Yes
Pregnant? ☐No ☐Yes
Number of children:_____
Number of pregnancies:_____
Age of first menstruation:_____
Age of menopause (if applicable):_____
Average number of days of flow:_____
Average number of days of entire cycle:_____
☐Vaginal discharge
color_________
☐Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

☐nausea ☐vomiting ☐water retention ☐breast swelling
☐food cravings ☐headaches ☐migraines ☐breast tenderness
☐depression ☐irritability ☐anxiety ☐other emotions:____________
☐dull pain, where?__________________ ☐sharp pain, where?____________________

Please fill in the following menstrual chart. If you are menopausal please fill in best to your recollection.

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Headaches/Migraines (check if yes)							
Other							

Men only

☐Swollen testes ☐Testicular pain ☐Impotence ☐Premature ejaculation
☐Feeling of coldness or numbness in external genitalia ☐Swollen Prostate
☐Other________________

Dietary Information History and Lifestyle:

Have you ever been on a restricted diet? ☐Yes (when, how long, type?) ☐No

What foods do you crave?

Do you get fatigued after eating certain foods? ☐Yes (which ones?) ☐No

Do you enjoy cooking? ☐Yes ☐No

Where do you do most of your grocery shopping?

What kinds of oils do you use in your food?

Please check ☑ one column for each row based on frequency:

Less than 1X Per Month	1-2X Per Month	1X Per Week	2-5X Per Week	1X or more Per Day	
					Alcoholic beverages
					Eat at restaurants
					Eat at "Fast Food" establishments
					Pastries, cookies, candies, ice cream, other sweets
					Add sugar to food/beverages
					Colas or other soft drinks
					Caffeine drinks/food
					Deep fried foods
					Margarine, hydrogenated oils, soy oil, corn oil
					Whole grains (rice, millet, oats)
					Red meat
					Poultry
					Fresh fish
					Processed cold cuts
					Fresh fruit
					Fresh vegetables
					Salads
					Sourdough breads
					White bread or flour products
					Beans/legumes
					Yogurt (brand?__________________)
					Milk
					Cheese
					Eggs
					Salt
					Herbs, fresh or dried
					Drink adequate water
					Eat if bored or depressed
					Eat in a hurry or rushed
					Chew food well
					Overeat – feel overfull after meals
					Distractions (TV, paper) while eating
					Sneak foods
					Artificial sweeteners
					Crave Sugar

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