Olive Branch Wellness Center, Inc.

Patient Intake and Health History Questionnaire

Personal Profile

Date _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone: Home _____ Work _____

Cell _____

Which numbers may we use to leave messages? Home ☐ Work ☐ Cell ☐

Email _____

Would you like to be emailed monthly newsletters? Yes ☐ No ☐

Marital Status: Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Partnership ◯

Live with: Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Pets ☐ Alone ☐

Occupation _____ Hours per week _____

Employer _____

Emergency Contact _____ Relationship to you _____

Emergency Contact Phone #_____

How did you hear about Olive Branch Wellness Center? _____

I certify that all information provided is correct. I also understand that all information provided on this intake form or during office visits is confidential. Information will only be released with my written and signed request.

Name_____Date _____

Your Ethnicity _____

Your Gender Male ◯ Female ◯

Date of Birth _____ Age _____
mm / dd /yyyy

Height _____′ _____″ Current Weight _____ Goal Weight _____

If current weight is different than goal weight, how long has it been since

you were at your goal weight?_____

Medical Information

****Please bring copies of Current (within the past 2 years) medical reports and laboratory tests to your appointment****

Primary Care Provider _____

Date of last medical or health care visit with primary _____

Reason for last visit _____

Date of last physical exam _____ Blood Type _____

Have you ever contracted an illness while traveling outside the country or shortly upon your return? Yes ◯ No ◯

If yes, please describe _____

What is your major complaint?

_____

When did it start? _____

What makes it better? _____

What makes it worse? _____

Does anything else happen at the same time?

_____

Other Complaints

_____

How long have you had this condition?_____

Have you ever had this or a similar condition in the past?_____

How long has it been since you have REALLY felt good?_____

List all previous diagnosis and treatments you have received prior to your present complaint:

Hospitalizations, Surgeries & Outpatient Procedures

Type	Date	Reason for Procedure	Outcome/Results

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Major Accidents & Traumatic Events

e.g.: car accident, serious shock, nervous breakdown, divorce or death of loved one

Type	Age	Duration	Complete Recovery	Treatment
			Y N	
			Y N	
			Y N	
			Y N	
			Y N	

Family History

Use the key below to identify family members and their associated health conditions
Please list type where parentheses are present.

M: Mother F: Father S: Sister B: Brother G: Grandparent A: Aunt U: Uncle C: Child

Allergies _____
Alcoholism_____
Anemia_____
Alzheimer's_____
Arthritis (Rheumatoid)_____
Arthritis (Osteo)_____
Asthma_____
Bleeding disorder_____
Cancer ( )_____
Cancer ( )_____
Celiac Disease _____
Crohns Disease_____
Colitis_____
Depression _____
Diabetes Type 1 _____
Diabetes Type 2 _____

Eczema_____
Epilepsy _____
Gout_____
Heart Disease_____
High Blood Pressure_____
High Cholesterol_____
Kidney Disease_____
Lupus_____
Mental Disorder_____
Nervous System Disease_____
Obesity_____
Stroke_____
Thyroid (Hypo/Hyper)_____
Other ( )_____
Other ( )_____

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Childhood/Adolescence History

How was your health as a child? Excellent ◯ Good (typical illnesses) ◯ Chronically Ill ◯

Were you troubled by: (Check all that apply)

Acne ☐ *Allergies* ☐ *Asthma* ☐ *Chronic Bronchitis* ☐ *Chronic Sore Throats* ☐ *Constipation* ☐

Chronic Ear Infections ☐ *Depression* ☐ *Fatigue* ☐ *Seizures* ☐ *Eczema* ☐ *Cancer* ☐ *Diarrhea* ☐ *Headaches* ☐

Skin Problems ☐ *Learning/Behavior Problems* ☐

Other _____

List medication(s) used for an extended period of time as a child:

_____

Were you overweight as a child/adolescent? Yes ◯ No ◯

What age range _____

How would you describe your experience of childhood/adolescence:

Happy/Secure ◯ Lonely Stress/Pressured ◯ Deprived of Love/Affection ◯

Abused: Verbally Physically Sexually ◯

Any significantchildhood/adolescentinjuries/illnesses/traumaticevents?

_____

For Males Only

Date of last testicular exam _____ Results _____

Date of last digital rectal exam (prostate exam) _____ Results _____

Date of last PSA blood test _____ Results _____

Do you experience any of the following? (check all that apply)

Low Libido ☐ Dribbling ☐ Decreased Stream ☐ Hesitancy ☐ Discharge ☐

Erectile Dysfunction ☐ Need to Urinate Multiple Times During the Night Pain ☐

Are you sexually active? Y ◯ N ◯

If yes, current form of contraception_____

Are there any questions/concerns regarding your sex life or intimacy you wish to discuss?

_____

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For Females Only

Date of last OB/GYN exam_____Results_____

Date of last PAP smear _____Results _____

Have you ever had an abnormal PAP? Y◯N◯

If yes, describe _____

Date of abnormal PAP _____

Date of last mammogram _____ Results _____

Date of last breast exam performed by physician _____

Are you sexually active? Y◯N◯ Current form of contraception_____

Have you ever used birth control pills? Y◯N◯

If yes, have you ever experienced any side effects from the pill? Explain

_____

Have you ever used an IUD? Y◯N◯ If yes, for how long? _____

What type of IUD?_____

If yes, have you ever experienced any side effects from the IUD?

_____

Age of firstmenstruation_____

Did you have a difficult time during puberty (i.e. physically, emotionally)? Yes◯ No◯

If yes, explain

_____

For Females Only *Continued*

If you experience PMS, please check all symptoms that apply:

Nervous Tension ☐ *Depression* ☐ *Headache* ☐ *Weight Gain* ☐

Irritability ☐ *Forgetfulness* ☐ *Craving Sweets* ☐ *Bloating* ☐

Mood Changes ☐ *Crying* ☐ *Increased Appetite* ☐ *Swelling of Hands/Feet* ☐

Anxiety ☐ *Confusion* ☐ *Heart Pounding* ☐ *Breast Tenderness* ☐

Insomnia ☐ *Dizziness or Fainting* ☐ *Cramping* ☐ *Fatigue* ☐

Periods occur every _____days. Do you ever skip periods? Y◯N◯

Date of last period _____ Periods usually last _____ days

Quantity of flow: Light◯ Moderate◯ Heavy◯

Number of tampons and/or pads used per day: Tampons _____ Pads _____

Quality of menstrual blood: Dark Red◯ Bright Red◯ Large Clots◯ Brown◯

Describe if necessary: _____

Are you Currently pregnant? Yes◯ No◯ Maybe◯

# of pregnancies (include current): # Births _____ # Miscarriages _____

Abortions_____

Any complications during pregnancy? Yes◯ No◯ If yes, please explain

_____

Did you breastfeed any of your children? Yes◯ No◯

If Yes, how many did you breastfeed? All◯ Some◯

Any problems with breastfeeding? Yes◯ No◯

If yes, please explain

_____

Are there any questions/concerns regarding your sex life or intimacy you wish to discuss?

_____

Have you reached any of the following?:

Peri-menopause ◯ Menopause ◯ Post-menopause ◯ None ◯

Date of last menstrual cycle_____

Are you taking any kind of hormone replacement therapy? Yes ◯ No ◯

When did you start taking HRT? _____

Type of HRT?_____ Dose _____

Have you had a hysterectomy? Yes ◯ No ◯

If yes: Partial ◯ Complete ◯ Date _____

Any complications from the hysterectomy? Yes ◯ No ◯

If yes please explain _____

Allergies

Do you suffer from allergies ? Yes ◯ No ◯

If yes, to what (ex grass, pollen, dust, animals, food)

_____

Have you ever experienced an anaphylaxis reaction? Yes ◯ No ◯

If yes, to what?_____

Have you had allergy testing? Yes ◯ No ◯

If yes what type_____

Results

_____

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Diet

List any specific foods or beverages you exclude from your diet, when and why?

_____

How many meals do you generally eat each day?

_____

Have you "yo-yo" dieted in the past? Yes ◯ No ◯ Explain;

_____

How often do you eat out or eat take-out foods?

_____

Are there specific foods that you feel you can't live without? Yes ◯ No ◯
If yes which ones?

_____

List any food or beverages that do not agree with you;

_____

Explain what happens when they don't agree with you;

_____

What foods do you crave?

_____

Do you consume Candy? Yes ◯ No ◯

How often? _____

Do you eat after dinner? _____

Do you feel you need something sweet after a meal ?_____

Do you feel sleepy after meals? Yes ◯ No ◯

Have you ever felt you have an eating disorder? Yes ◯ No ◯

If yes, please explain_____

Typical daily water intake is _____ oz OR _____ glasses

# of cups or glasses of the following per day

_____*Coffee* _____ *Tea* _____ *Pop* _____ *Juice* _____ *Wine*

_____*Beer* _____ *Liquor/Mixed Drinks*

Sleep

Average Hours per night _____

Do you have trouble falling asleep? Yes ◯ No ◯

If yes, what keeps you awake?

_____

How long does it take you to fall asleep? _____

Do you have trouble staying asleep? Yes ◯ No ◯

If yes, how many times do you wake per night and is there a consistent time that you wake through-out the night? _____

Do you snore? Yes ◯ No ◯

If yes, please describe:

_____

Do you have recurring dreams? Yes ◯ No ◯

If yes, please describe:

_____

Do you wake refreshed? Yes ◯ No ◯

What time do you go to bed? _____What time do you get up? _____

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The Strength For Life Good Health Brings

Today's Date _____

Please initial and date the following statements:

I understand payment is due at the time of service _____

I understand that my insurance will not be billed _____

Recommendations made do not supersede or are not in lieu of any medical advice by your physician. _____

When need be I will be referred out for further care. _____

I have supplied a current list of all medications and supplements that I utilize and will be asked to update this list at each visit. _____

I will provide copies of current medical information if necessary for review. _____

I will provide information regarding other health care professionals that I am seeing on each time I am asked to do so. _____

I ALSO UNDERSTAND THAT IF I DO NOT CANCEL AN APPOINTMENT 24HRS PRIOR I WILL BE CHARGED $75.00. _____

Supplements I am currently taking:	Medications and over the counter items I am taking:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____

Signature

t 630.370.7290 www.olivebwc.com 461 Briargate Drive South Elgin IL 60177

Olive Branch Wellness Center, Inc.

The Strength For Life Good Health Brings

Patient Information
Please Print

Date _____

Name _____

Address _____

_____

Phone

Home _____

Work _____

Cell _____

Date of Birth _____

E-Mail address _____

Emergency Contact Information:

Name _____

Phone # _____

Relation to you _____

How did you hear of us?

_____

Today's Date _____

I understand that Naturopathic Medicine is not currently licensed in the state of Illinois, and that by obtaining information from the Unlicensed physician I am not able to bill my insurance company.

Name _____

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