INTAKE FORM

WYLDHERON ALTERNATIVE HEALTH

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Date:

THIS INFORMATION IS CONFIDENTIAL

Name: _____ M/F

Address:_____

City:_____ State:_____ Zip:_____

Day Phone:_____ Alternate Phone:_____

E-mail:_____

Birth Date:_____ Age:_____ Height:_____ Weight:_____

Occupation:_____

Ancestral Origin:_____

What is your chief health concern?

Are there other areas of well-being that you'd like to address?

How would you rate your overall health today? (1(poor) to 10 (excellent)

Name and phone number of your primary physician:_____

Date of last physical exam:_____ Gyn Exam:_____

What active medical conditions are you currently receiving treatment for?

Condition	Date Started	Treatment
1.		
2.		
3.		
4.		
5.		

Please list all medications you are currently using (include hormones & non-prescription medicines):

Name:_____ Dose:_____ Time/day:_____
Name:_____ Dose:_____ Time/day:_____
Name:_____ Dose:_____ Time/day:_____
Name:_____ Dose:_____ Time/day:_____
Name:_____ Dose:_____ Time/day:_____

Please list any drug allergies you have experienced:

Please list any adverse reactions to herbs or other non-prescription medications:

Please list any food , environmental, animal or other allergies you have:

Please list any chemical, metal or radiation exposure you have at home or at work (i.e. dental filings, pesticides, solvents, radon, etc.):

Please list any alternative therapies you are using:

Please all herbs and vitamin supplements that you are currently taking:

Are you experiencing any of the following? Please indicate & describe:

Pain
Fever
Vomiting

Diarrhea
Unusual color of bowel movement (dark/light/blood)
Frequent urination
Blood in the urine
Night sweats
Depression with thoughts of suicide
Unusual abdominal bloating
Numbness, tingling or paralysis
Recent fainting or loss of consciousness
Lumps, swellings, sore lymph nodes
Bleeding of any kind
Unusual or persistent fatigue
Sudden changes in sense perception, memory or speech
Erectile dysfunction

Please list any traumas or hospitalizations:

What is your infectious history from childhood to the present?

Have you or anyone in your family ever had:

	Self	Family	Relationship
Allergies/Asthma	____	_____	_____
Alcohol/Addiction	____	_____	_____
Arthritis	____	_____	_____
Bowel Disease	____	_____	_____
Cancer or tumor	____	_____	_____

Diabetes ____ _____ _____

Eating Disorder ____ _____ _____

Emphysema ____ _____ _____

Food intolerance ____ _____ _____

Glaucoma ____ _____ _____

Heart Disease ____ _____ _____

High Blood Pressure ____ _____ _____

HIV/AIDS ____ _____ _____

Kidney/Bladder problems ____ _____ _____

Lung Disease ____ _____ _____

Mental Illness ____ _____ _____

Migraine Headaches ____ _____ _____

Osteoporosis ____ _____ _____

Stroke ____ _____ _____

Thyroid problems ____ _____ _____

Toxic or chemical exposure ____ _____ _____

Tuberculosis ____ _____ _____

Ulcers ____ _____ _____

How much do you smoke? ____ Per day ____ Per week

How much alcohol ? ____ Per day ____ Per week

How much coffee? ____ Per day ____ Per week

How many soft drinks? ____ Per day ____ Per week

How many diet drinks? ____ Per day ____ Per week

How much water? ____ Per day ____ Per week

Recreational Drug use? ____ Per day ____ Per week

Exercise Summary: How much do you;

Run/swim/cycle/dance/aerobics? _____ per day _____ per week

Walk/Hike ? _____ per day _____ per week

Engage in resistance exercise ? _____ per day _____ per week

Describe any limitation or problems you have with activity or exercise:

Number of hours you sleep each night (average): _____
Do you wake up during the night? _____ Number of times: _____
Do you sleep well & wake up refreshed?
Do you have trouble falling asleep?
Are you sleepy or fatigued during the day?
Do you have a history of snoring or sleep apnea?
Do you take sleeping medications or other aids to fall asleep?

DIET:
Do you follow any specific diet? Specify.

What diets have you tried in the past?

What foods do you consistently overeat?

What foods do you crave? (sweets, bread, pasta, chocolate, salty, fatty or other foods)

What food(s) could you not live without?

A typical days diet would look like:
Breakfast:

Lunch:

Dinner:

Snacks:

On a scale of 1 to 10, please rate the following at the present time:
Energy level:
Appetite:
Diet:
Sleep:
Exercise:
Symptoms:
Attitude:

What do you think is the source of your health condition(s)?