Wellness Learning Center
455 E. Paces Ferry Rd, Suite 201, Atlanta, GA 30305
Office: 404-233-0208 Fax: 404-264-1470

CONFIDENTIAL PATIENT HEALTH RECORD

Date_____

Name_____ Phones H _____
Address_____ W_____
_____ C_____

E-mail address_____ Birth date_____ Height_____ Weight _____
Sex M F Age_____ Marital Status S M D W How many children? _____ Ages_____
Occupation _____ Employer_____
Spouse's name_____ Employer_____
Emergency contact _____ Phone Number_____
Family Doctor_____ Phone Number_____
Who referred you? _____

Please list your major health concern, or the reason for this appointment. What caused it? If it's pain, is it sharp, dull, stabbing, aching, tingling, burning, or numbing? Is it getting worse?

_____
_____
_____

How have you dealt with this in the past? Was the treatment effective?

_____
_____

Is it the result of an accident? Auto___ Work___ Home___ Other_____ Accident date_____ Disabled from work? Y N
Doctors consulted for the condition:
Date: _____ Name_____ _____ Specialty_____
Diagnosis/treatment_____ Result_____
Date: _____ Name_____ Specialty_____
Diagnosis/treatment_____ Result_____
Which of the following affect your trouble? (Circle as many as apply.)

Movement	Reaching up/down	During the night	2-4 hours after meals	Driving
Standing	First thing in the AM	Walking	Time of greatest activity	Near end of day
Lying down	While resting	Bending	Before meals	Coughing
Exercising	Sitting	Twisting	After meals	Sneezing

Date of last physical exam_____ By Doctor_____ Results _____
_____Chest X Ray _____
Spinal X-rays_____ Blood Tests_____ Urine Tests _____Other tests_____
Please list any surgeries you have had. Please include the date(s) of surgery.

_____
_____
_____
_____

Any surgical implants? Y N Explain _____

List serious accidents and falls and the date of the incident.

_____

_____

_____

Medications and or vitamins/supplements you take:

What_____Frequency_____ How long taking _____
What_____Frequency_____ How long taking _____
What_____Frequency_____ How long taking _____
What_____Frequency_____ How long taking _____

Family health information:

	Age/Deceased	Diabetes	Heart	Kidney	Cancer	Musculo-skeletal
Father						
Mother						
Brothers						
Sisters						

Please circle any of the following that you are allergic to

Penicillin Mycins Sulpha Drugs Aspirin
Morphine Serums Adhesive Tape Nail Polish
Tetanus Codeine Antitoxin

Any Foods Y N Explain _____
Any Other Drugs Y N Explain _____
Any Other Cosmetics Y N Explain _____

Health Habits: Do you…..

Exercise Adequately? Y N
How do you exercise? _____ How Often_____
Awaken Rested? Y N
Sleep Well? Y N
Average 8 hours sleep per night? Y N
Have regular bowel movements? Y N
Like your work? Y N

Work _____ hours per day?
Work indoors or outdoors? I O
Watch TV ____ hours per day?
Read _____ hours per day?
Vacation ____ weeks per year?
Ever been treated for Alcoholism? Y N
Ever been treated for drug abuse? Y N

Please circle all of the following that you are currently taking;

Antacids Aspirin/Tylenol Laxatives Relaxants / Sleeping
Antibiotics Chemotherapy/Radiation Lithium Thyroid Medication
Antidepressants Cortisone / Anti-inflammatories Oral Contraceptives / HRT Ulcer Medication
Antidibetic / Insulin Heart/high blood pressure Recreational Drugs Other _____

Dental work and doctor's name for TMJ, bridges, dentures, braces_____

_____

Rate your level of stress from 1 to 10 (10 being the highest)_____

Do you have sufficient energy for your normal activities? Y N

When was the last time you really felt good?_____

Circle any of the following you have or have ever had:

Anemia	Cold Sores	Gout	Measles	Pneumonia	Tuberculosis
Appendicitis	Diabetes	Heart Disease	Mental Disorders	Polio	Typhoid fever
Arthritis	Diphtheria	Hepatitis	Multiple Sclerosis	Rheumatic Fever	Ulcer
Cancer	Emphysema	Influenza	Muscular Dystrophy	Scarlet Fever	Whooping Cough
Chicken Pox	Epilepsy	Lumbago	Mumps	Sexual Transmitted	Other _____
Cholera	Goiter	Malaria	Pleurisy	Stroke	Other _____

Circle Current Conditions – Check Former Conditions:

General Symptoms:
Tremors
Headaches
Fever
Chills/Sweats
Dizziness/Fainting
Convulsions
Loss of Sleep
Fatigue
Nervousness
Depression
Loss/Gain Weight
Numbness or Pain
where?
Paralysis
Forgetfulness
Confusion

Eyes, Ears, Nose and Throat:
Failing Vision
Near Sightedness
Crossed Eyes
Eye Pain/Strain
Eye Inflammation
Deafness
Earache
Ear Noises
Ear Discharge
Nose Bleeds
Nasal Obstruction
Sore Throat
Hoarseness
Difficult Speech
Hay Fever/Allergies
Gum Troubles
Frequent Colds
Enlarged Thyroid
Tonsillitis
Sinus Infection
Nasal Drainage
Enlarged Glands

Skin:
Skin Eruptions
Itching
Bruising easily
Dryness
Boils
Rashes/Hives
Sensitive Skin
Eczema

Respiratory:
Asthma
Chronic Cough
Spitting Up Phlegm
Spitting Up Blood
Chest Pain
Difficulty Breathing
Wheezing

Cardio-vascular:
Rapid heart beat
Slow heart beat
High blood pressure
Low blood pressure
Pain over heart
Heart Attack
Hardening of arteries
Swelling of ankles
Poor circulation
Heart attack
Paralytic Stroke
Varicose veins

Muscle and Joints:
Stiff neck
Backache
Swollen joints
Painful tailbone
Foot trouble
Pain between shoulders
Hernia
Spinal curvature
(scoliosis)
Faulty posture
Arthritis
Stiff joints
Painful joints
Sore muscles
Weak muscles
Walking problems
Sciatica
Orthotics – how long?

Genitounrinary:
Frequent urination
Scant urination
Blood/Pus in Urine
Kidney Infection/stones
Bed-wetting
Inability o control urine
Prostate trouble
Bladder trouble
Discolored urine

Gastrointestinal:
Poor appetite
Excessive hunger
Difficult chewing
Difficult swallowing
Belching or gas
Nausea

Vomiting / blood
Pain over stomach
Distension of abdomen
Constipation
Diarrhea
Heartburn/Reflux
Black / Bloody stool
Haemorrhoid (piles)
Parasites/Worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis / Diverticulitis/IBS
Weight trouble
Antibiotic therapy

Female:
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Previous miscarriage
Vaginal discharge
Vaginal pain
Congested breast
Breast pain
Lumps in breast
Menopausal symptoms
Polycystic ovaries
Miscarriage
When was your last
period?

Are you pregnant?
Yes
No
Not sure

METABOLIC ASSESSMENT FORM

Name: _____ **Age:** ____ **Sex:** ____ **Date:** _____

PART I **Please list your 5 major health concerns in your order of importance:**

1. _____

2. _____

3. _____

4. _____

5. _____

PART II **Please circle the appropriate number "0 to 3" on all questions below.**
0 being the least or never and 3 being the most or always.

Category 1				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard dry or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
Use laxatives frequently	0	1	2	3
Category 2				
Excessive belching burping or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits or vegetables	0	1	2	3
Undigested foods found in stool	0	1	2	3
Category 3				
Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3
Frequent use of antacids	0	1	2	3
Feeling hungry 1 or 2 hours after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol or caffeine	0	1	2	3
Category 4				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side	0	1	2	3
Bloating under ribcage	0	1	2	3
Excessive passage of gas	0	1	2	3
Stool: undigested, foul smelling, mucous like, greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category 5				
Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth especially in a.m.	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skim, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	0	1	2	3
Category 6				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to get started or keep going	0	1	2	3
Get light headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category 7				
Fatigue after meals	0	1	2	3
Crave sweets during the day				
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal to or larger than hip girth	0	1	2	3
Increased urination	0	1	2	3
Increased thirst appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category 8				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category 9

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category 10

Tired, sluggish	0	1	2	3
Feel cold – hands feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category 11

Heart palpations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category 12

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category 13

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category 14 (males only)

Urination difficulty or dribbling	0	1	2	3
Urination more frequent	0	1	2	3

Category 14 (males only) continued

Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category 15 (males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in past	0	1	2	3

Category 16 (Menstruating females only)

Are you perimenopausal	Yes			No
Alternating menstrual cycle lengths	Yes			No
Extended cycle, greater than 32 days	Yes			No
Shortened cycle, less than 24 days	Yes			No
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/ thinning	0	1	2	3

Category 17 (Menopausal females only)

How many years have you been menopausal?	___			
Have you had uterine bleeding since menopause?	Yes			No
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

PART III

How many alcohol beverages do you consume per day/week? _____

How many calleinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

How many times a week do you eat raw nuts or seeds? _____

How many times do you workout? _____

List the three worst foods you eat during the average week? _____

List the three healthiest foods you eat during the average week? _____

Do you smoke? ____ If yes, how many times per day, ____ per wk ? ____ Rate your stress levels on a scale of 1-10 during the average week. ____

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

4 Day Meal Journal

Name -

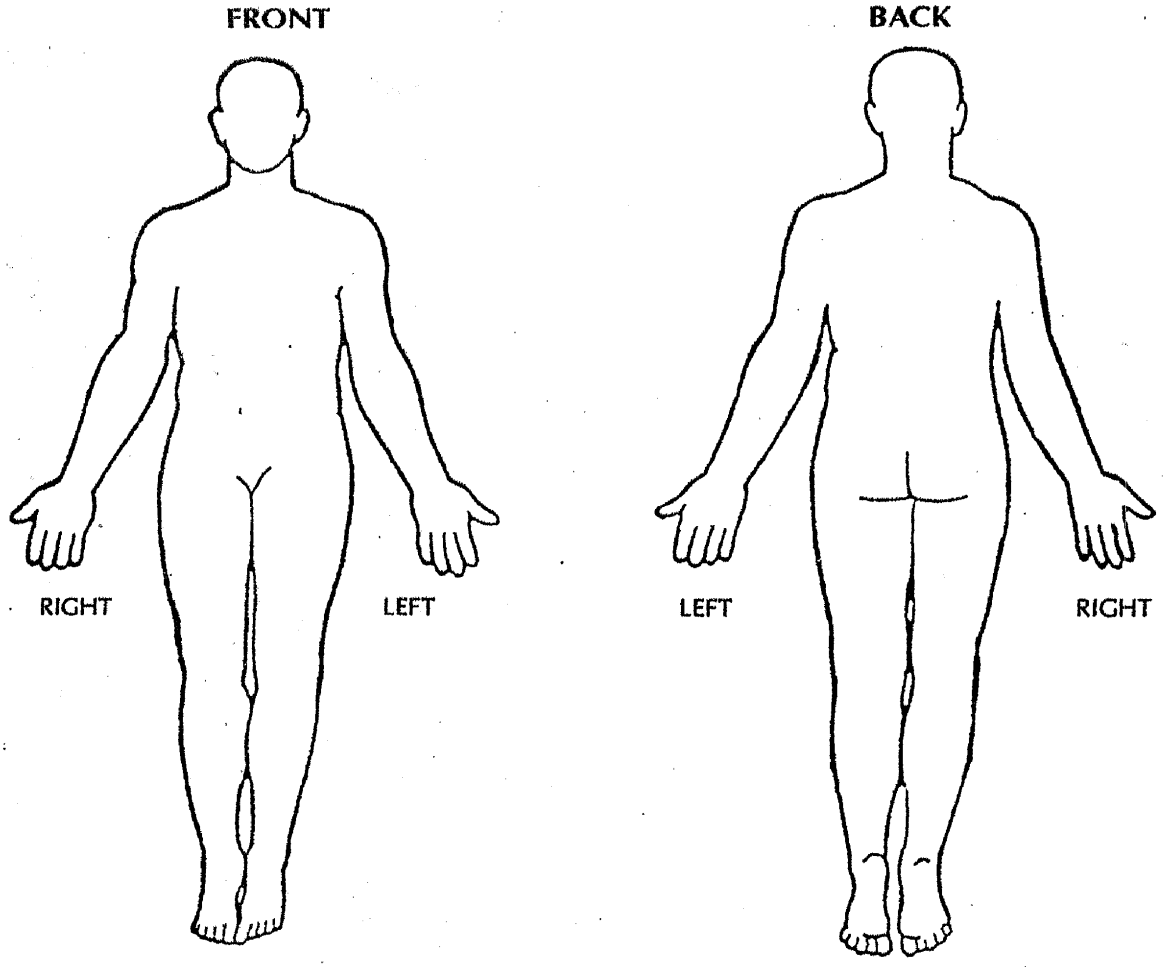
Meal	Day 1	Day 2	Day 3	Day 4
breakfast				
lunch				
dinner				
snacks				
drinks				

Pain Drawing Assessment

Draw the location of your pain on the body outlines using the appropriate symbol. Include all affected areas. Just to complete picture, please draw in your face. Mark the severity of your pain at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
ZZZ	BBB	XXXX	= = =	////
ZZZ	BBB	XX	= = =	//

Percentage of pain in back _____ Percentange of pain in legs _____



NO PAIN 1 2 3 4 5 6 7 8 9 10 INTOLERABLE PAIN

CIRCLE YOUR PAIN ESTIMATE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I under that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance carrier, and that any amoun authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all servic rendered me are charged directly to me and that I am personally responsible for payment. I also understnad that if I suspend or terminate my care at th office, any outstanding charges for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ SS# _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Please return this completed form to the receptionist.

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE INFORMATION REQUESTED ON THE ADDITIONAL SHEET