The Personal Wellness Center

6508 Deer Pointe Dr., Suite 4C, Salisbury, D 21804 – P: 410-742-6016

LIFESTYLE FORM

Name_____ Telephones: (w) _____ (h) _____

Address _____ Zip Code _____

Referred by_____ For_____

VITAL STATISTICS

Date of Birth_____ Age_____ Height_____ Desired Weight_____

Gender_____ Blood Type _____ Ethnic Background_____

Age of Puberty_____ # Children_____ Menstrual Cycle: # of days _____ Menopause Age_____

PURPOSE OF VISIT

Primary_____

Secondary_____

MEDICAL HISTORY

Infancy: Were you breastfed?_____ How long?_____ Formula Type: Cow___ Goat___ Soy___

Childhood Health Problems_____

Teenage Health Problems_____

Adult Health Problems_____

Family Diseases/History_____

Father: Alive Age_____ Health Problems_____

Dead Age of Death:_____ Cause:_____

Mother: Alive Age_____ Health Problems_____

Dead Age of Death:_____ Cause:_____

Has any blood relative ever had any of the following? Please circle yes or no.

Breast Cancer	Yes	No	Heart Trouble	Yes	No
Colon Cancer	Yes	No	Stroke	Yes	No
Prostate Cancer	Yes	No	Suicide	Yes	No
Tuberculosis	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Epilepsy	Yes	No

Injuries _____

Surgeries _____ Complications _____

Medications Presently Taking _____

Previous Long-Term Medications (contraceptives) _____

Current Physician _____ Telephone # _____ Town _____

Last Visit _____ Diagnosis _____

Other Therapists _____

LIFESTYLE

Occupation _____ Long Hours?_____

Major Life Stresses _____

Frequently Travel _____ Frequently Eat at Restaurants? _____

Wear Glasses/Contact Lenses _____ Strength _____ What Color Tint? _____

Dental Disease of Surgery _____ Do you wear dentures? _____

Water Source: Tap _____ Well _____ Filtered _____ Bottled _____

Do you smoke? _____ How much? _____ How many years? _____

Do you drink Alcohol? _____ How much? _____ How many years? _____

Exercise? _____ Type? _____ Time per session? _____ Sessions per week? _____

Fatigued/Drowsy? _____ Daily Energy Peaks _____ Daily Energy Lows _____

Hours of Sleep at Night _____ __ Dreams about Health _____ Nightmares _____

_____

DIET PATTERNS

APPETITE

How strong is your appetite?

Milk, Cheese, Yogurt

_____

(strong - medium - light)

When are you the hungriest?

_____

Favorite Foods?

_____

_____

Food Dislikes?

_____

_____

MEAL TIMING:

List time & size of meals:

Snack _____

Dinner _____

Bedtime _____

DIGESTION:

(check symptoms)

_____Gas & Bloating

_____ Cramps, Colitis

_____Nausea, Vomiting

_____ Ulcers, Ulcerative Colitis

_____ Irritable Bowel Syndrome

_____ Bile, Gall Stones, Jaundice

_____ Constipation, Hemorrhoids

_____ Diarrhea, Hemorrhoids

_____ Light Floating Stools

_____Undigested Food in Stools

_____ Candida, Yeast Infections

FOODS EATEN: (List # days per week)

Breakfast _____

Lunch _____

Milk, Cheese, Yogurt _____

Eggs _____

Red Meats _____

Poultry _____

Fish _____

Shellfish _____

Grains _____

Nut Seeds _____

Beans _____

Salad _____

Vegetables _____

Tomato, Bell Pepper _____

Fruits _____

ETHNIC:

Italian Food, Pizza _____

Mexican Food _____

Mid Eastern, Indian Food _____

Oriental Food _____

OTHER:

Coffee, Black Tea _____

Sodas, Colds _____

Alcohol _____

Chocolate: candy bars, etc. _____

Corn Syrup: candy, etc. _____

Sugar: cakes, cookies, donuts, etc. _____

Honey _____

Aspartame _____

Salt: added, crackers, chips _____

Spices _____

Sauces, Gravy _____

Ice Cream _____

Butter/Margarine _____