burien wellness

PATIENT INFORMATION

Date _____

Name _____ _____ _____
Last First Middle Initial

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age _____ Birthday ___/___/___

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Insurance Provider _____

Prefix and ID# _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

_____

HOW CAN WE HELP YOU?

What brings you in today? ☐ Wellness ☐ Pregnancy ☐ Accident ☐ Physical Complaint

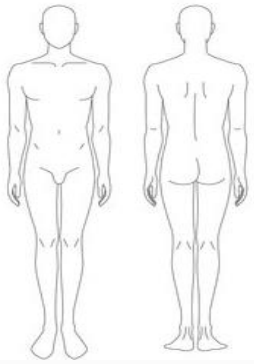
Please describe: _____

How long has this been an issue?_____

How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Aching ☐ Sharp
☐ Tingling ☐ Cramping ☐ Shooting
☐ Stiffness ☐ Nagging ☐ Burning
☐ Dull ☐ Stabbing ☐ Throbbing
☐ Swelling ☐ Other_____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other_____	☐	☐	☐	☐

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10

NOT COMMITTED — VERY COMMITTED

PATIENT WELLNESS ASSESSMENT

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

Immediate _____

Short Term _____

Long Term _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

_____

Are you currently pregnant? ☐ No ☐ Yes, due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

_____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you **have** or **have had**.

☐ AIDS/HIV
☐ Alcoholism
☐ Anxiety
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma/Allergies
☐ Back Pain
☐ Cardiovascular Issues
☐ Cancer
☐ Circulation Issues
☐ Childhood Illness
☐ Depression
☐ Diabetes
☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
☐ Elbow/Wrist/Hand Issues
☐ Endocrine Issues (Thyroid)
☐ Foot/Ankle Issues
☐ Gout
☐ Headaches/Migraines
☐ Heart Disease
☐ Hepatitis
☐ Hip Issues
☐ Immune Issues
☐ Lymphatic Issues
☐ Multiple Sclerosis
☐ Neck Pain
☐ Reproductive Issues
☐ Ringing in Ears
☐ Scoliosis
☐ Shoulder Issues
☐ Stroke
☐ TMJ Issues
☐ Urinary Issues
☐ Osteoporosis
☐ Other_____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

Please list below.

ALLERGIES_____ MEDICATIONS_____ SUPPLEMENTS_____

_____ _____ _____

_____ _____ _____