Physician Assisted Wellness
Jonathan Sheline, MD

Demographic and Insurance Information

General Information

Name_____ Age_____ Date_____

Date of Birth_____ Gender ___male ___female

Primary Address _____

Phone: Cell_____; Home_____; Work_____

E-mail address_____

Emergency Contact (Name, relationship)_____

Their Phone _____; Their E-mail _____

Your Job Title_____

Nature of Business_____

Primary Care Physician: *Name*_____*Phone*_____

*Address*_____*Fax*_____

Referred By_____

Insurance Information

Primary Insurance Co.: Name_____; ID# _____

Name of primary insured _____; Relation to insured: _____; Start date _____

Group number _____; Employer name _____

Secondary Insurance Co. (Name, ID#): _____

Authorization For Release of Information To Your Insurance Company

I hereby authorize the release of information required in the course of my treatment necessary to process insurance claims. This permission will remain in effect until revoked by me in writing.

Signature of insured _____; Date _____

Pharmacy Information

Primary Pharmacy: Name_____Phone_____

Address_____Fax_____

Credit Card Information

This information will be kept in a secure location at all times. **[If you are concerned, you may leave this blank, for now].** It will be used to secure your new client appointment and to cover the cost of phone consultations, missed appointments and other services. We accept VISA, MasterCard and Discover.

Primary Card

Name on Card_____ Card Type_____

Account Number_____ Expiration Date_____ CVV _____

Billing Zip Code_____

Allergies

Medication/Supplement/Food	Reaction

Primary Concerns

What is the purpose for today's visit?

What are the three top problems you would like to solve?

Please list current and ongoing problems in order of priority to you:

Describe problem (ex: fatigue)	mild	mod	severe	Prior treatment & results

Medical, Surgical History

Please list any medical diagnoses or conditions, and surgeries, now or in the past, and provide dates.

Hospitalizations

Date	Reason

Additional Comments about Medical History:

Women's Health History

Obstetric: dates of all births (and gender of child), miscarriages, and abortions:

Menstruation/hormonal issues (irregular periods, PMS, infertility, menopausal issues (hot flashes), low libido, incontinence (with onset dates):

Additional Comments About Women's Health History:

Men's Health History

Decreased urine flow or hesitancy, frequent urination, prostate enlargement, erection problems, low testosterone, low libido (with onset dates):

Additional Comments About Men's Health History:

Medications and Supplements

Current Medications

Medication	Dose	Frequency	Start Date (mo/yr)	Reason for Use

Previous Medications (past 2 years)

Medication	Dose	Frequency	Start Date (mo/yr)	Reason for Use

Nutritional Supplements (Vitamins, Minerals, Herbs, Homeopathy)

Supplement/Brand	Dose	Frequency	Start Date (mo/yr)	Reason for Use

Have your medications or supplements ever caused problems or side effects?

Have you had prolonged or regular use of NSAIDS (ibuprofen, Aleve, Advil, etc) or aspirin?

Have you had prolonged or regular use of acid blocking drugs (Prilosec, Nexium, ranitidine, etc)?

Prolonged use of oral steroids (e.g. prednisone) , or inhaled steroids (Advair, fluticasone) in the past?

Family Health History

Please fill in all known information for blood relatives only: (Be sure to include: coronary artery disease, heart attacks, hypertension, diabetes, pre-diabetes, autoimmune diseases (e.g. lupus), depression, other mental illness, alcohol or drug abuse, cancer(s)/type, dementia, osteoporosis, thyroid disease)

Family Member	Age	Major Health Issues	Age at Death	Cause of Death
Mother				
Father				
Siblings #1 (M or F)				
#2 (M or F)				
#3 (M or F)				
#4 (M or F)				
Others: kids, aunts, uncles, grandparents				

Note: If you were adopted, please fill in what you know about your biological or blood relatives.

Do you have any special concerns about your family health history?

Nutrition History

Have you made any changes in your eating habits because of your health?

If so, describe:_____

Do you currently follow a special diet or food plan?

Explain:_____

Height (ft/in)	Current weight
Usual weight range	Desired weight range

Highest adult weight	Lowest adult weight
Frequent weight fluctuations?	

How often do you weigh yourself?

What foods do you avoid?

What are your absolute favorite foods?

Do you grocery shop? If not, who does your shopping?

Do you read food labels?

Do you cook? If not, who does your cooking?

How many meals do you eat out per week?

The important thing I should change about my diet to improve my health is:_____

_____

Psychosocial History

Would you describe your experience as a child in your family as happy and secure?

What type of work do you do? Where?

How many hours per week do you typically spend at work?

Do you enjoy your job? Explain.

Who do you live with currently?

What are your current major stressors (personal, work, relationships, health, etc.)?

Do you believe stress is presently reducing the quality of your life?

Do you have any significant relationship concerns? Explain.

Do you feel your life has meaning and purpose?

What are your hobbies?

Are you actively engaged in any of them currently? Explain.

What do you do for fun? How often?

Have you ever been abused, a victim of a crime, or experienced significant trauma? Explain.

Personal Habits

Smoking

Do you currently smoke? How many years? Packs per day?

Attempts to quit?

Are you a former smoker? For how long? When did you quit?

Alcohol

How many drinks currently per week? Circle below: *[1 drink=5 ounces wine, 12 oz. beer, 1.5 oz. spirits]*

None 1-3 4-6 7-10 >10

Previous alcohol intake? Mild Moderate High None

Have you ever been told you should cut down your alcohol intake?

Do you get annoyed when people ask about your drinking?

Do you ever feel guilty about your alcohol consumption?

Do you ever need a drink 1st thing in the morning to get going?

Do you notice a tolerance to alcohol (can you "hold" more than you used to)?

Have you ever been unable to remember what you did during a drinking episode?

Have you ever been arrested or hospitalized because of drinking?

Have you had problems with your job due to drinking (current or past?)

Have you had problems with a relationship due to drinking (current or past?)

Have you ever thought about getting help to control or stop your drinking?

Other Substances

Caffeine Intake? Coffee cups/day: Tea cups/day:

Caffeinated sodas or diet soda intake per day:

List favorite types:

Are you currently using any recreational drugs? What type?

Exercise

Type	Frequency per week	Duration in Minutes

Rate your level of motivation to exercise: Low Medium High

List problems that limit activity:_____

_____

Sleep

Average number of hours you sleep each night:

Do you have trouble falling to sleep?

Do you have trouble staying asleep? How many times do you wake up each night?

Do you feel rested upon awakening?

Do you wake up to an alarm?

Do you have problems with insomnia?

Do you snore?

Do you use any sleep aids? Explain:_____

Roles/Relationships

Marital Status: single married partnered separated divorced widowed

Any children? If so, give names, ages, genders: _____

_____

Who is living in household? Number_____ Names_____

Resources for emotional support?

How well have things been going for you?	Very Well	Fine	Poorly	N/A
Overall				
At school/ job (specify which)				
In your social life (with friends)				
With sex				
With your well-being				
With your spouse or significant other				
With other family (parents, children)				

Environmental and Detoxification Assessment

Do you have adverse food reactions or sensitivities? If so, list all_____

_____

Do you have any food allergies? If so, list all_____

Do you have an adverse reaction to caffeine? _____ What? _____

Do you react adversely to any of the following: Artificial colors Artificial sweeteners Milk Cheese

Alcohol Preservatives Other: _____

Exposures in your home or work: Chemicals Mold Radiation Other?_____

Self Care

What obstacles to you see as standing in the way of self-care:

How supportive will others in your household be as you work on implementing the above changes?

What do you need to support you on your journey to health and wellness?

Symptom Review

Please circle all symptoms you have experienced in the past 3 months.

General	**Intolerance of foods:**	**Cardiovascular**
Cold intolerance	Dairy (? Lactose intolerance)	Angina/chest pain
Daytime sleepiness	Wheat	Irregular or skipped heartbeats
Difficulty falling to sleep	Gluten	Swollen ankles or feet
Early/frequent wakening	Corn	Other:
Fatigue	Eggs	**Respiratory**
Fever	Other:	Asthma or wheezing
Heat intolerance	**Skin problems**	Frequent cough
Weight loss or gain	Acne	Shortness of breath
Other:	Fungal infections (incl. nails)	Snoring
Head, Eyes, Ears	Hives, rashes, dry skin	Other:
Congestion (nose/sinus)	Other:	**Musculoskeletal**
Eye pain	**Digestion**	Joint pain/stiffness
Hay fever	Abdominal pain/cramping	Joint swelling/redness
Hearing loss	Bloating	Muscle pain
Headache	Burping, passing excessive gas	Other:
Post-nasal drip	Constipation	**Urinary**
Vision problems	Diarrhea	Frequent or urgent urination
Other:	Heartburn, reflux	Hesitancy, slow stream
Mood/Neurological	Nausea or vomiting	Kidney stones
Anxiety	Other:	Leaking/incontinence
Depression	**Male reproductive**	Other:
Difficulty concentrating	Erectile dysfunction	**Eating problems**
Dizziness	Poor libido (sex drive)	Binge eating/drinking
Irritability	**Female reproductive**	Bulimia
Memory problems	Poor libido (sex drive)	Craving certain foods
Migraine headaches	Premenstrual symptoms	Excessive weight
Other:	Sweating or hot flashes	Fluid retention

Your Health and Major Life Event Timeline

Please record all major health events (include childhood infections/treatments, significant illnesses and symptoms) as well as all major life events (births, deaths, relationships, traumas, major stresses).

Year/Age
Birth to 1 yr
1-4 years
5-9 years
10-19
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90-99

Three Day Diet Diary

What we eat is enormously important to our health and vitality. Exploring your current eating habits will provide invaluable clues about symptoms and problems you may be experiencing and will show us what changes need to be made to improve or optimize your health. Please complete this three-day diet diary on 3 consecutive, "typical" days, including at least one weekend day if possible.

-Record the information as soon as possible after eating.
-Do not change your normal eating behavior for the purpose of this diary.
-Describe the food or beverage consumed: e.g. toast—what kind of bread; chicken—fried, baked, etc.
-Record the amount of food eaten: 8 ounces, ½ cup, 1 teaspoon, etc.
-Include any added items: e.g. tea with 1 tsp of sugar, potato with 2 tsp of butter, etc.

-Include any spices or seasonings you use.

-Record all beverages, including water.

-List, with an asterix (*), all bowel movements and if they were unusually hard or soft.

Date/Time	Food	Amount	Time	Beverage	Amount

Date/Time	Food	Amount	Time	Beverage	Amount

Additional information or comments:

Thank you so much for the time and effort you have put into completing this questionnaire! I look forward to your visit!

Jonathan Sheline, MD | Physician Assisted Wellness