LEHIGH VALLEY WELLNESS CENTER
101 Coventry Drive
Phillipsburg, NJ 08865

CLIENT INTAKE FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Full Name:		Gender: ○Male ○ Female
Address:		DOB:
State:		City:
Zip Code:		Email:
Phone:		Secondary Phone:

Marital Status: ○Single ○ Partnered ○ Married ○ Separated ○Divorced ○ Widowed

Previous or Referring Practitioner:	Date of last physical exam:

PERSONAL HEALTH HISTORY

Childhood Illness:	○ Measles ○Mumps ○Rubella ○ Chickenpox ○Polio ○ Rheumatic ○ Fever ○ Other: _____

Immunizations and Dates:	Tetanus:	Chicken Pox:
	Pneumonia:	Influenza:
	Hepatitis:	MMR:

List any medical problems that other providers have diagnosed:

_____

_____

_____

_____

Surgeries:		
Year	Reason	Hospital/Facility

Other Hospitalizations:		
Year	Reason	Hospital/Facility

Have you ever had a blood transfusion?	○ Yes ○ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
Drug Name	Strength	Frequency Taken

Allergies to medications	
Drug Name	Reaction

HEALTH HABITS AND PERSONAL SAFETY

Exercise:	○ Sedentary (No exercise)	○ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	○ Occasional vigorous exercise (i.e. work Or recreation)	○ Regular vigorous exercise

Diet:	Are you dieting?	○ Yes ○ No
	If yes, are you on a practitioner prescribed medical diet?	○ Yes ○ No

	Number of meals you eat in an average day?	_____
	Rank salt intake	○ High ○ Medium ○ Low
	Rank fat intake	○ High ○ Medium ○ Low
	Do you have cravings for sugar and/or processed, starchy foods?	○ Yes ○ No

Caffeine:	○ None ○ Coffee ○ Tea ○ Cola	
	Number of cups/cans per day? _____	

Foods:	Beef/Pork/Lamb	○ Every day ○ Often ○Sometimes ○ Never
	Fish	○ Every day ○ Often ○Sometimes ○ Never
	Chicken	○ Every day ○ Often ○Sometimes ○ Never
	Fresh Vegetables	○ Every day ○ Often ○Sometimes ○ Never
	Fresh Fruit	○ Every day ○ Often ○Sometimes ○ Never
	Fast Foods	○ Every day ○ Often ○Sometimes ○ Never
	Cookies, Pastries, Cakes	○ Every day ○ Often ○Sometimes ○ Never
	Canned Foods	○ Every day ○ Often ○Sometimes ○ Never
	Soda, including Diet	○ Every day ○ Often ○Sometimes ○ Never
	Sugar or Sugary Foods	○ Every day ○ Often ○Sometimes ○ Never
	Whole Grains	○ Every day ○ Often ○Sometimes ○ Never
	Dairy Products	○ Every day ○ Often ○Sometimes ○ Never
	Raw seeds and/or Nuts	○ Every day ○ Often ○Sometimes ○ Never
	Olive Oil	○ Every day ○ Often ○Sometimes ○ Never
	Fried Foods	○ Every day ○ Often ○Sometimes ○ Never
	Packaged Snack Foods	○ Every day ○ Often ○Sometimes ○ Never
	Beans, Lentils, or Peas	○ Every day ○ Often ○Sometimes ○ Never
	Raw Foods	○ Every day ○ Often ○Sometimes ○ Never
	Eggs	○ Every day ○ Often ○Sometimes ○ Never
	Cold Breakfast Foods (Cereals)	○ Every day ○ Often ○Sometimes ○ Never
	Hot Breakfast Foods	○ Every day ○ Often ○Sometimes ○ Never
	Prepackaged Foods	○ Every day ○ Often ○Sometimes ○ Never
	Organic Foods	○ Every day ○ Often ○Sometimes ○ Never
	White Rice	○ Every day ○ Often ○Sometimes ○ Never
	Whole Grain/ Long Grain Rice	○ Every day ○ Often ○Sometimes ○ Never

Water:	Do you drink water?	○ Yes ○ No
	How much water do you drink (number of glasses per day)?	_____
	What type of water do you drink: ○ Bottled ○ Tap ○ Filtered ○ Reverse Osmosis ○ Flavored	
	Do you drink water only when you are thirsty?	○ Yes ○ No

Alcohol:	Do you drink alcohol?	○ Yes ○ No
	If yes, what kind?	_____
	How many drinks per week?	_____
	Are you concerned about the amount you drink?	○ Yes ○ No
	Have you considered stopping?	○ Yes ○ No
	Have you ever experienced blackouts?	○ Yes ○ No
	Are you prone to “binge” drinking?	○ Yes ○ No

	Do you drive after drinking?	○ Yes ○ No

Tobacco:	Do you use tobacco?	○ Yes ○ No
	_____ Cigarettes – pks./day	_____ chew - #/day
	_____ Pipe - #/day	_____ Cigars - #/day
	_____ # of years	_____ or year quit

Drugs:	Do you currently use recreational or street drugs?	○ Yes ○ No
	Have you ever given yourself street drugs with a needle?	○ Yes ○ No

Sex:	Are you sexually active?	○ Yes ○ No
	Are you using contraceptives or barrier method for STDs?	○ Yes ○ No
	Any discomfort with intercourse?	○ Yes ○ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	○ Yes ○ No

Personal Safety:	Do you live alone?	○ Yes ○ No
	Do you have frequent falls?	○ Yes ○ No
	Are you afraid for your personal safety?	○ Yes ○ No
	Have you had any major exposure to toxic chemicals?	○ Yes ○ No
	If yes, please explain: _____ _____	
	Have you been exposed to radiation, including x-rays? Dental X-rays?	○ Yes ○ No
	Have you been exposed to radon, asbestos, or lead?	○ Yes ○ No
	Have you ever had any physical attacks or assaults either by a family member and/or stranger?	○ Yes ○ No

FAMILY HEALTH HISTORY

AGE	SIGNIFICANT HEALTH PROBLEMS	
Father	_____	
Mother	_____	

MENTAL HEALTH	
Is stress a major problem for you?	○ Yes ○ No
Do you feel depressed?	○ Yes ○ No
Do you panic when stressed?	○ Yes ○ No
Do you have problems with eating or your appetite?	○ Yes ○ No
Do you cry frequently?	○ Yes ○ No
Have you ever attempted suicide?	○ Yes ○ No
Have you ever seriously thought about hurting yourself?	○ Yes ○ No
Do you have trouble sleeping?	○ Yes ○ No
Have you ever been to a counselor?	○ Yes ○ No
Is your job or occupation fulfilling for you?	○ Yes ○ No
Is your job stressful?	○ Yes ○ No
Do you feel connected to the world of nature?	○ Yes ○ No
Do you have pets?	○ Yes ○ No
Do you have a sense of spirituality, regular spiritual practice (if that's important to you)?	○ Yes ○ No
Do you feel that you have an underlying purpose in your life?	○ Yes ○ No
Do you feel you have enough quality time alone?	○ Yes ○ No
Do you have creative outlets to vent your stress and/or negative energy?	○ Yes ○ No
Any other issues you would like to address? _____ _____ _____	

WOMEN ONLY	
Age at onset of menstruation: _____	
Date of last menstruation: _____	
Period: every _____ days	
Heavy periods, irregularity, spotting, pain, or discharge?	○ Yes ○ No
Number of pregnancies: _____ Number of live births: _____	
Are you pregnant or breastfeeding?	○ Yes ○ No
Have you had a D&C, hysterectomy, or Cesarean?	○ Yes ○ No
Any urinary tract, bladder, or kidney infections with the last year?	○ Yes ○ No
Any blood in your urine?	○ Yes ○ No
Any problems with control of urination?	○ Yes ○ No
Any hot flashes or sweating at night?	○ Yes ○ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	○ Yes ○ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	○ Yes ○ No
Do you have trouble sleeping?	○ Yes ○ No
Are you pregnant or are you trying for pregnancy?	○ Yes ○ No

MEN ONLY	
Do you usually get up to urinate during the night?	○ Yes ○ No
If yes, number of times _____	
Do you feel pain or burning with urination?	○ Yes ○ No
Any blood in your urine?	○ Yes ○ No
Do you feel burning discharge from penis?	○ Yes ○ No
Has the force of your urination decreased?	○ Yes ○ No
Have you had any kidney, bladder, or prostate infections with the last 12 months?	○ Yes ○ No
Do you have any problems emptying your bladder completely?	○ Yes ○ No
Any difficulty with erection or ejaculation?	○ Yes ○ No
Any testicle pain or swelling?	○ Yes ○ No
Date of last prostate and rectal exam: _____	

REVIEW OF SYSTEMS (Check off all that apply)

_____ Recent weight changes	_____ Changes in nail/hair	_____ Urination problems
_____ Weakness	_____ Headaches	_____ Arthritis
_____ Fever	_____ Vision Problems	_____ Back Pain
_____ Night Sweats	_____ Glaucoma or Cataracts	_____ Neck Pain
_____ Cough	_____ Dry Eyes	_____ Other Pain: _____
_____ Sputum Production	_____ Earaches	_____ Numbness in hands/feet
_____ Blood in Sputum	_____ Sinus Problems	_____ Seizures
_____ Asthma, Bronchitis	_____ Thyroid Problems	_____ Tremors
_____ Emphysema	_____ Chest Pain	_____ Dizziness
_____ TB	_____ Shortness of Breath	_____ Depression
_____ Rashes	_____ Leg Swelling	_____ Anxiety
_____ Easy Bruising	_____ Heartburn	_____ Nausea or Vomiting
_____ Color Change (skin)	_____ Diarrhea	_____Constipation
_____ Excessive Dryness (skin)	_____ Excessive Perspiration	

Describe anything not listed above that is bothersome for you:

_____

_____

_____

TREATMENT QUESTIONNAIRE (Answer **ALL** That Apply)			
Decreased Concentration	○ Yes ○ No	Decreased sociability	○ Yes ○ No
Increased mood swings	○ Yes ○ No	Decreased short term memory	○ Yes ○ No
Increased stress levels	○ Yes ○ No	Decreased long term memory	○ Yes ○ No
Decreased personal drive	○ Yes ○ No	Decreased sense of well being	○ Yes ○ No
Depression	○ Yes ○ No	Feeling less confident	○ Yes ○ No
Difficulties sleeping	○ Yes ○ No	Decreased sex drive	○ Yes ○ No
Decreased energy	○ Yes ○ No	Decreased endurance	○ Yes ○ No
Decreased exercise	○ Yes ○ No	Healing from exercise is long	○ Yes ○ No

Decreased muscle strength	○ Yes ○ No	Decreased testicle size	○ Yes ○ No
Decreased skin elasticity	○ Yes ○ No	Decreased skin tone	○ Yes ○ No
Decreased libido	○ Yes ○ No	Increased fat deposits	○ Yes ○ No
Increased wrinkles	○ Yes ○ No	Increased muscle deterioration	○ Yes ○ No
Increased fatigue	○ Yes ○ No	Gynocomastia (male breast)	○ Yes ○ No
Nipple sensitivity	○ Yes ○ No	Hot Flashes	○ Yes ○ No
Heavy menstrual cycle	○ Yes ○ No	Painful menstrual cycle	○ Yes ○ No
Temperature intolerance	○ Yes ○ No	Oral birth control or estrogen	○ Yes ○ No
Thinning or loss of hair	○ Yes ○ No	Thinning pubic hair	○ Yes ○ No
Sagging or loose skin	○ Yes ○ No	Thin/dry skin	○ Yes ○ No
Stiff joints in morning	○ Yes ○ No	Decreased bone mass	○ Yes ○ No
Progressive osteoporosis	○ Yes ○ No	Increased joint pain	○ Yes ○ No
Increased back pain	○ Yes ○ No	Gastrointestinal bleeding	○ Yes ○ No
Muscle aches and pains	○ Yes ○ No	Joint pain during exercise	○ Yes ○ No

HEALTH INFORMATION AUTHORIZATION

Patient Name: _____ | Date of Birth: _____ (mm/dd/yyyy)

As required by the HIPAA Privacy Regulations, this practice may not use or disclose your protected health information without your authorization.

Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize the staff of **Lehigh Valley Wellness Center** to use and/or disclose certain protected health information (PHI) about me to individual/facilities, health care insurance companies involved with my health care.

This authorization permits **Lehigh Valley Wellness Center** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.)

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI except by the health care insurance companies for the purposes of payment of services rendered to you for your care.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy office at: **Lehigh Valley Wellness Center** at **101 Coventry Drive, Phillipsburg, NJ 08865.**

Signed by: _____ _____
Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____
Print Patient's Name | Date

_____
Print Name of Patient or Legal Guardian, if applicable

Consent for Treatment:

I hereby authorize **Lehigh Valley** or any its employees to use the information in this questionnaire to evaluate my present health states and provide recommendations for improving my health and wellness.

I am aware that the recommendations may consist of dietary modifications, the addition of vitamin/mineral and herbal supplements, exercise routines and/or other alternative treatments such as massage or chiropractic care.

These recommendations are based on the evaluation of the practitioner which are formulated by the findings of an interview, a physical assessment and review of the information provided in this questionnaire.

Client Signature: _____ Date: _____