

Riegler, Shienvold & Associates
HEALTH & WELLNESS INTAKE QUESTIONNAIRE

The information that you provide in this questionnaire is meant to assist us in providing the best diagnosis and treatment possible. The information you provide is strictly confidential and will become part of your medical record.

Name: _____ **Date:** _____

Current or Referring Doctor: _____ **Date of Last Exam:** _____

How would you rate your present health? Excellent Good Fair Poor

Do you have any of these communicable diseases? Tuberculosis Hepatitis Other _____

Health and Wellness Information

Do you have any other medical problems? No Yes

If Yes, indicate nature of problem: _____

Exercise:	<input type="checkbox"/> Sedentary (no exercise) <input type="checkbox"/> Mild Exercise (climb stairs, frequent walks, golf) <input type="checkbox"/> Occasional vigorous exercise (less than 4 times per week for 30 min.) <input type="checkbox"/> Vigorous exercise (more than 4 times per week for 30 min.)
Diet:	Current Weight: _____ Have you recently gained/lost weight? (circle one) <input type="checkbox"/> No <input type="checkbox"/> Yes How much? _____ Are you dieting? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what plan are you using? _____
Caffeine:	Do you use any of the following? <input type="checkbox"/> Caffeinated sodas or energy drinks How much? _____ <input type="checkbox"/> Tea How much? _____ <input type="checkbox"/> Coffee How much? _____
Sleep:	Do you sleep well? <input type="checkbox"/> No <input type="checkbox"/> Yes If no, check all that apply <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Difficulty staying asleep <input type="checkbox"/> Excessive sleep <input type="checkbox"/> Restless, tossing and turning
Tobacco:	Do you use tobacco? (check below) <input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never <input type="checkbox"/> Cigarettes <input type="checkbox"/> Snuff If previously, how long did you use? _____ <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing tobacco If previously, when did you quit? _____ <input type="checkbox"/> Pipe If currently, how much? _____
Allergies: List any foods or medications that you may be allergic to.	<input type="checkbox"/> Penicillin <input type="checkbox"/> Others (please list) <input type="checkbox"/> Sulfa drugs <input type="checkbox"/> Aspirin

HISTORY OF ILLNESS OR SYMPTOMS

ILLNESSES: (Have you had or do you have any of the following? Check all that apply.)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Alcohol problem | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Other drug problems | <input type="checkbox"/> Sick cell trait | <input type="checkbox"/> Head injuries | |

Please indicate any symptoms, conditions, or surgeries you have had in the categories below.

CATEGORY	Describe symptoms, conditions, or surgeries
EYES, EARS, NOSE, THROAT, AND HEAD:	
HEART, and CIRCULATORY SYSTEM:	
LUNGS:	
STOMACH and ABDOMINAL:	
MUSCLES, JOINTS, AND BONES:	
SKIN:	
BLOOD:	
NEUROLOGY:	
GENITO-URINARY, GYNECOLOGICAL:	

MEDICATION Please list all prescription, Over-the-counter, and herbal medications you are taking

Medication Name	Dose	Medication Name	Dose	Medication Name	Dose