

Cherri Schleicher FNPc APNP FMCHC

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**General Information** **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

First Middle Last

**Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Month Day Year

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_**

**Gender: Male\_\_\_\_\_\_\_\_\_ Female\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please check the following: \_\_\_\_\_\_**African American \_\_\_\_\_\_\_Native American\_\_\_\_\_\_ Hispanic\_\_\_\_\_\_\_\_Caucasian

\_\_\_\_\_\_\_Mediterranean\_\_\_\_\_\_\_\_Northern European\_\_\_\_\_\_Asian\_\_\_\_\_\_\_\_Other \_\_\_\_\_\_\_\_\_

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_**

**Nature of Business: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status: \_\_\_\_\_\_\_**Single \_\_\_\_\_\_\_Married \_\_\_\_\_\_\_\_Divorce \_\_\_\_\_\_Widowed \_\_\_\_\_\_Long Term Partnership

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_**

Name (relationship)

**Primary Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_**

**Physician** Name Phone

**(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Fax

**Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**(2)**

**Please List all food or Drug Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What Kind of Reactions to these Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What do you Hope to Achieve with your Visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When was the last time you felt well? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What caused the change in your health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What makes you feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What makes you feel better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you could permanently eliminate three problems, what would they be?**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Concerns** (please list in order of importance)

**Concern Severity Past/Present Treatments Success Level**

**#1**

**#2**

**#3**

**#4**

**#5**

**#6**

**#7**

**#8**

**What physician or other health care provider (complimentary therapies) have you seen for these conditions? (i.e. acupuncture, massage therapist, physical therapy)?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How much time have you lost from work or school in the past year due to these conditions?**

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**Medications/ Supplements/ Over the Counter Products**

**Name Strength Dosage Reason Duration**

**Within the past six months, circle any that apply**

**Pain Relievers Antacids Antibiotics Birth Control**

**Blood pressure Hormones Insulin Laxatives**

**Sedatives Steroids Tranquilizers**

**How often have you taken antibiotics?\_\_\_\_\_\_\_\_\_\_\_\_\_\_Childhood?\_\_\_\_\_\_\_\_\_\_Adulthood?\_\_\_\_\_\_\_\_\_\_**

**Social History:**

With whom do you live? (include ages)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where do you live? \_\_\_\_\_\_\_city\_\_\_\_\_\_\_\_\_suburb\_\_\_\_\_\_\_\_\_\_\_apartment\_\_\_\_\_\_\_farm\_\_\_\_\_\_country

Do you have any pets or farm animals? \_\_\_\_\_\_\_\_\_\_\_\_yes\_\_\_\_\_\_\_\_\_\_no

If so, do they live indoors/outdoors or both? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you lived or traveled outside the United States? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

If so, when and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What city and state did you grow up in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ rural or industrial? \_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_ Past\_\_\_\_\_\_ Quantity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_ Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interests/Hobbies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often to you engage in these hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you watch TV/ Computer games? Yes\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_Hours/day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take vacations? YES\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_week(s) off/year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where do you like to vacation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you or your family recently experienced any major life changes or losses? Yes\_\_\_\_ No\_\_\_\_\_

If so please comment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Important is religion (or spirituality) for you and your family’s life?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_not at all important
2. \_\_\_\_\_\_\_\_\_\_\_\_\_somewhat important
3. \_\_\_\_\_\_\_\_\_\_\_\_\_extremely important

How much time have you lost from work or school in the past year?

1. \_\_\_\_\_\_\_\_\_\_\_\_ 0-2 days
2. \_\_\_\_\_\_\_\_\_\_\_\_3-14 days
3. \_\_\_\_\_\_\_\_\_\_\_\_> 15 days

Previous jobs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High School/ Technical/ College’s attended\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical and sexual are leading contributors to chronic stress, illness and immune system dysfunction. Witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes. Please do your best to answer the following questions.

1. Did you feel safe growing up? Yes\_\_\_\_\_\_\_\_\_ no\_\_\_\_\_\_\_\_\_\_
2. Have you been involved in abusive relationships in your life? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_
3. Was alcoholism or substance abuse present in your childhood home? Yes\_\_\_\_\_\_\_No\_\_\_\_\_
4. Is alcoholism or substance abuse present now in your relationships? Yes\_\_\_\_\_No\_\_\_\_
5. Do you currently feel safe in your home? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_
6. Do you feel safe, respected, and valued in your current relationship? Yes\_\_\_\_No\_\_\_\_
7. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse? Yes\_\_\_\_\_ No\_\_\_\_
8. Would you feel safer discussing any of these issues privately? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

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**Past Medical and Surgical History** (check only those that apply)

**Gastrointestinal**

**Diagnosis/ Condition Past Ongoing Comments**

**Celiac disease**

**Crohn’s**

**Gastritis**

**GERD**

**Gallstones**

**Irritable Bowel Syndrome**

**Other**

**Cardiovascular**

**Diagnosis/Condition Past Ongoing Comments**

**Heart Disease**

**Heart Attack**

**Elevated Blood pressure**

**Elevated Cholesterol**

**Stroke**

**Rheumatic Fever**

**Mitral Valve Prolapse**

**Irregular Heart Beat**

**Other**

**Musculoskeletal**

**Diagnosis/Condition Past Ongoing Comments**

**Osteoarthritis**

**Fibromyalgia**

**Chronic Pain**

**Other**

**Cancer**

**Diagnosis/Condition Past Ongoing Comments**

**Lung**

**Breast**

**Colon**

**Skin**

**Ovarian/ Prostate**

**Other**

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**Metabolic/Endocrine**

**Diagnosis/Condition Past Ongoing Comments**

**Diabetes**

**Hypothyroidism**

**Hyperthyroidism**

**Polycystic Ovarian Syndrome**

**Infertility**

**Weight gain/Loss**

**Bulimia**

**Anorexia**

**Metabolic syndrome**

**Other**

**Inflammatory/ autoimmune**

**Diagnosis/ Condition Past Ongoing Comments**

**Chronic Fatigue Syndrome**

**Rheumatoid Arthritis**

**Lupus**

**Poor Immune Function**

**Food allergies**

**Environmental Allergies**

**Other**

**Genital & Urinary Systems**

**Diagnosis/Condition Past Ongoing Comments**

**Kidney stones**

**Gout**

**Interstitial Cystitis**

**Yeast Infections**

**Sexual Dysfunction**

**Other**

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**Respiratory Disease**

**Diagnosis/Condition Past Ongoing Comments**

**Asthma**

**Chronic Sinusitis**

**Bronchitis**

**Emphysema**

**Tuberculosis**

**Sleep Apnea**

**Other**

**Neurologic/Mood**

**Diagnosis/Condition Past Ongoing Comments**

**Depression**

**Anxiety**

**Bipolar disorder**

**Schizophrenia**

**Headache/Migraine**

**ADD/ADHD**

**Autism**

**Memory Problems**

**Mild cognitive Impairment**

**Parkinson’s**

**ALS**

**Alzheimer’s**

**Other**

**Skin**

**Diagnosis/Condition Past Ongoing Comments**

**Eczema**

**Psoriasis**

**Acne**

**Other**

**Have you had any of the following Diseases?** (check those that apply and age)

**Chicken Pox\_\_\_\_\_\_\_\_\_\_\_ German Measles\_\_\_\_\_\_\_\_\_ Measles\_\_\_\_\_\_\_\_\_ Mononucleosis\_\_\_\_\_\_\_\_**

**Mumps\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Whooping cough\_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Surgeries** (please check those that apply)

**Appendectomy\_\_\_\_\_\_**

**Gall Bladder\_\_\_\_\_\_\_\_\_**

**Tonsillectomy\_\_\_\_\_\_\_\_**

**Hernia\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Joint Replacement\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Heart surgery Bypass or Valve\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pacemaker\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hysterectomy +/- Ovaries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dental Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Childhood history**

**Question Yes No Don’t Know Comments**

1. Were you a full-term baby?
2. A Preemie?
3. Breast fed? If so, how long?
4. Bottle Fed?
5. Cesarean Birth?
6. As a child did you eat a lot of sugar? Candy?
7. As a Child were there any foods that you had to avoid because they gave you symptoms? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_

If yes can you please name the food and symptom (Example milk-diarrhea) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you have home cooked meals growing up? Yes\_\_\_\_\_\_\_\_\_ no\_\_\_\_\_\_\_ Type of diet\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Did you go out to eat a lot growing up? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_ types of restaurants? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Were you vaccinated as a child? Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_

If vaccinated can you check vaccines received; Tetanus\_\_\_\_\_\_\_\_ Polio\_\_\_\_\_\_\_\_ Hepatitis \_\_\_\_\_\_\_\_ Measles\_\_\_\_\_\_\_

Mumps\_\_\_\_\_\_\_\_ Rubella\_\_\_\_\_\_\_\_\_ Polio\_\_\_\_\_\_\_\_\_ Small pox\_\_\_\_\_\_\_ Diphtheria\_\_\_\_\_\_Pertussis\_\_\_\_\_\_\_\_

**Gynecological history** (for women only)

Age of First Period? \_\_\_\_\_\_\_\_ Menses Frequency? \_\_\_\_\_\_\_\_\_ Length? \_\_\_\_\_\_\_ Pain? Yes\_\_\_ No\_\_\_\_

Clotting? Yes\_\_\_\_ No\_\_\_\_ Has your period every skipped? Yes\_\_\_\_ No\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_

Last Menstrual Period\_\_\_\_\_\_\_\_\_\_ Age of Menopause\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use of hormonal contraception such as; Birth control pills\_\_\_\_\_\_\_\_Patch\_\_\_\_\_\_\_ NuvaRing\_\_\_\_\_\_\_\_\_

Depo-Provera\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use contraception? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_ Condom\_\_\_\_\_\_\_\_\_Diaphragm\_\_\_\_\_\_\_\_\_

IUD\_\_\_\_\_\_\_\_\_\_Partner Vasectomy\_\_\_\_\_\_\_\_\_\_\_

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Do you experience symptoms during the second half of your menstrual cycle; such as breast tenderness water retention or PMS symptoms? Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Pap test? \_\_\_\_\_\_\_ Have you ever had an abnormal? \_\_\_\_\_\_\_\_\_\_\_\_Treatment if any? \_\_\_\_\_\_\_\_\_\_

Bone Density\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_

Last Mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_Results? \_\_\_\_\_\_\_\_\_\_\_Thermography? \_\_\_\_\_\_\_\_\_Results? \_\_\_\_\_\_

Have you every had an abnormal mammogram? \_\_\_\_\_\_\_\_\_\_\_\_ If yes treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use hormone replacement therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in menopause? \_\_\_\_\_\_\_\_\_\_\_

Do you experience any of the following?

Hot flashes\_\_\_\_\_\_\_\_ Vaginal Dryness\_\_\_\_\_\_\_\_ Weight gain\_\_\_\_\_\_\_\_ Mood swings\_\_\_\_\_\_\_\_\_

Decreased Libido\_\_\_\_\_\_\_\_\_\_ Loss of control of urine\_\_\_\_\_\_\_ Heavy Bleeding\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss of concentration/Memory\_\_\_\_\_\_\_\_\_ Palpitations\_\_\_\_\_\_\_\_\_\_ Headaches\_\_\_\_\_\_\_\_\_\_\_\_

**Obstetric History** (please provide yes or no and number of)

Pregnancies\_\_\_\_\_\_\_\_\_\_ Caesarean\_\_\_\_\_\_\_\_\_\_ Vaginal\_\_\_\_\_\_\_\_\_\_\_\_

Miscarriage\_\_\_\_\_\_\_\_\_\_ Abortion\_\_\_\_\_\_\_\_\_\_\_ Living Children\_\_\_\_\_\_\_\_\_\_

Post Partum Depression\_\_\_\_\_\_\_\_\_\_\_ Toxemia\_\_\_\_\_\_\_\_\_\_

Gestational Diabetes\_\_\_\_\_\_\_\_\_\_ Breast feeding/ how long\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Men’s History**

Have you ever had a PSA done? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

PSA Level; 0-2\_\_\_\_\_\_\_\_ 2-4\_\_\_\_\_\_\_\_\_\_ 4-10\_\_\_\_\_\_\_\_\_\_\_ >10\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the following?

Prostate Enlargement? \_\_\_\_\_\_\_\_\_\_\_\_ Prostate Infection? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Change in Libido\_\_\_\_\_\_\_\_\_\_\_\_ Impotence\_\_\_\_\_\_\_\_\_\_\_

Difficulty Obtaining an Erection\_\_\_\_\_\_\_\_\_\_ Difficulty maintaining an Erection\_\_\_\_\_\_\_\_\_\_\_

Urination at night; Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_ How many times at night? \_\_\_\_\_\_\_\_\_\_\_

Urgency/ Hesitancy/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Loss of control of Urine\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diet/Nutritional History**

Typical Breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_

Typical Lunch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_

Typical Dinner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_

Snacks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Timing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you grocery shop and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you read food labels? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

Dietary restrictions or food aversions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food cravings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time of day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time between meals\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Main sources of protein\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you purchase organic fruits and vegetables Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_  
Do you purchase organic meat? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_

Water intake: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Beverages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you cook? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_ Do you enjoy cooking? Yes\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

If no who does the cooking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you go out to eat? Yes\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_ Times per week/ month\_\_\_\_\_\_\_\_\_\_\_\_

Types of foods you like at restaurants if you eat out? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an adverse reaction to Caffeine? Yes\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Past Quantity/Week

Alcohol

Coffee and or Tea

Soda: Diet Regular

Milk: Cow Goat %fat

Soymilk Almond Coconut

Check all the factors that apply to your current lifestyle and eating habits?

\_\_\_\_\_\_\_\_Erratic eating patterns \_\_\_\_\_\_\_\_\_\_Love to eat

\_\_\_\_\_\_\_\_Fast Eater \_\_\_\_\_\_\_\_\_\_Eat because I have to

\_\_\_\_\_\_\_\_Late night eating \_\_\_\_\_\_\_\_\_\_Have a negative relationship with food

\_\_\_\_\_\_\_\_Dislike healthy food \_\_\_\_\_\_\_\_\_\_Struggle with eating issues

\_\_\_\_\_\_\_\_Significant other or family \_\_\_\_\_\_\_\_\_\_Emotional eater (eat when sad, lonely

Members don’t like healthy foods Depressed bored

\_\_\_\_\_\_\_\_Eat 50% or > meals away from \_\_\_\_\_\_\_\_\_\_Eat too much under stress

Home

\_\_\_\_\_\_\_\_Travel frequently \_\_\_\_\_\_\_\_\_\_Eat too little under stress

\_\_\_\_\_\_\_\_Healthy foods not available \_\_\_\_\_\_\_\_\_\_Eating in the middle of night

\_\_\_\_\_\_\_\_Do not plan meals or menus \_\_\_\_\_\_\_\_\_\_Confused about nutrition advice

\_\_\_\_\_\_\_\_Reliance on convenience \_\_\_\_\_\_\_\_\_\_Significant other or family members have

\_\_\_\_\_\_\_\_Poor snack choices special dietary needs or food preferences

\_\_\_\_\_\_\_\_Time constraints \_\_\_\_\_\_\_\_\_\_Eat in car

Do you currently follow a specific diet or Nutritional program? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have symptoms after eating such as bloating, belching, sneezing, hives? Yes\_\_\_\_\_\_No\_\_\_\_\_\_

Is yes are they associated with a particular food or supplement? Yes\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_

Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you feel worse when you eat a lot of?** **Do you feel better when you eat a lot of?**

High fat foods\_\_\_\_\_\_\_\_\_\_\_ High fat foods\_\_\_\_\_\_\_\_\_\_\_\_\_

High Protein foods\_\_\_\_\_\_\_\_\_ High Protein foods\_\_\_\_\_\_\_\_\_\_\_

High carbohydrate foods\_\_\_\_\_\_\_\_ High carbohydrate foods\_\_\_\_\_\_\_\_

(breads, pasta, potatoes)

Refined Sugar (junk food) \_\_\_\_\_\_\_\_ Refined Sugar (junk food) \_\_\_\_\_\_\_\_\_

Fried foods\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fried foods\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1 or 2 alcoholic drinks\_\_\_\_\_\_\_\_\_\_\_ 1 0r 2 alcoholic drinks\_\_\_\_\_\_\_\_\_\_\_\_

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Does skipping meals affect your symptoms? Yes\_\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_

What foods do you not tolerate well?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much fluid do you drink with your meals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times do you chew your food? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep History**

How many hours of sleep do you get a night? \_\_\_\_\_\_\_\_Do you have problems with insomnia?

Yes No Past Comments

Wake refreshed?

Fall asleep easily (within 20 minutes)

Wake to urinate?

Wake at other times?

Do you snore?

Do you stop breathing during sleep?

Do you use sleep aides?

Sleep Aides Tried in past? Taking now? Dosage? Helpful or not?

Ambien

Sonata

Lunesta

Belsomra

Valium

Ativan

Restoril

Tylenol PM

Benadryl

Calcium/Magnesium

Valerian

Kava

Melatonin

5 HTP

Coffea Cruda

Quietude

Others

Have you had a sleep study performed? \_\_\_\_\_\_\_\_\_

Do you use a CPAP machine? Yes\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_

Do you take naps? Yes\_\_\_\_\_\_no\_\_\_\_\_\_\_\_\_How long? \_\_\_\_\_\_\_\_Do you feel more rested? \_\_\_\_\_\_\_\_\_

If it takes longer than 20 minutes, what do you do to try to fall asleep?

(e.g. read, watch TV, computer, phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel wired at night difficult to fall asleep? Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

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Have you had a saliva cortisol test? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

Do you feel the need to move your feet or legs at night or been diagnosed with restless leg Syndrome? Yes\_\_\_\_No\_\_\_

What time do you usually go to bed and what time do you wake? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you go to bed at a good time and if not, what time would that be? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear a sleep monitoring device? If so type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On the weekends or days off do you vary your sleep schedule? Yes\_\_\_\_No\_\_\_\_\_  
Do you have young children that wake you? Yes\_\_\_\_No\_\_\_\_\_

Do noises wake you up? Yes\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_

Do you sleep with animal that snores or moves around? Yes\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_

Does your partner snore? Yes\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_  
Do you wake because of pain? Yes\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_

What type of bed do you have and what size is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of pillow, bed sheets and comforter do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use body pillows? Yes\_\_\_\_No\_\_\_\_\_ How many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you remember your dreams? Yes\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_ Do you have nightmares? Yes\_\_\_\_\_\_No\_\_

Do you feel safe in your bedroom? Yes\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_

**Exercise**

Do you exercise regularly? Yes\_\_\_\_ No\_\_\_\_\_\_

Current exercise program; (List type of activity, number of sessions per week and duration)

Activity Type Frequency per week Duration in Minutes

Walking/Jogging

Stretching

Strength training

Yoga/Pilates

Sports/Leisure (golf, tennis)

Swimming

Other

Rate your level of motivation for including exercise in your life? \_\_\_\_\_\_\_low \_\_\_\_\_\_medium\_\_\_\_\_high

List any problems that limit activity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel unusually fatigued after exercise? \_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you usually sweat when exercising? \_\_\_\_\_\_\_Yes\_\_\_\_\_\_\_\_\_no \_\_\_\_\_\_\_\_\_\_\_\_\_sometimes

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**(13)**

**Environmental Assessment**

(please check the box if indicated)

**Household** Current Past Reaction

Leaded Paint

Live near Industrial area

Live near cell phone tower

New carpet/paint/

Remodeling

Pesticide/Insecticide use/lawns

Pesticide/ Insecticide Farm

Dry cleaning

Smoking in household

**Work** Current Past Type Reaction

Solvent

Chemicals

Lead

Heavy metals

Fumes

Smoke

Do you dry clean your clothes? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or have you worked in a damp or moldy environment or had other mold exposures including where you grew up? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_No Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your home been tested for Radon? Yes\_\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_Remediated\_\_\_\_\_\_\_\_\_\_\_\_

What types of personal care/cleaning products do you use? If you make your own, please list ingredients.

Deodarant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lotion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Make-up\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toothpaste\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Body soap/ Shampoos\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Floor cleaners\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Furniture cleaners\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Detergents\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Perfumes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have WIFI in your home? \_\_\_\_\_\_\_\_yes\_\_\_\_\_\_\_No Where is your Router located? \_\_\_\_\_\_\_\_\_\_\_\_

Anything else you would like to tell me about your work environment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your home environment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drive to work? \_\_\_\_\_\_\_\_\_\_Yes\_\_\_\_\_\_\_\_\_\_No Travel time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Self-Care Questionnaire**

(please rate the following questions 0-5 0 never 1 rarely 2 sometimes 3 Often 4 Regularly 5 Always)

Physical

1. Eat a whole foods diet rich in colorful veggies/fruits 0 1 2 3 4 5
2. Drink enough water/ 0 1 2 3 4 5
3. Exercise for 20 minutes or more daily 0 1 2 3 4 5
4. Take time to breath deeply throughout the day 0 1 2 3 4 5
5. Spend time in nature? 0 1 2 3 4 5
6. Feel nourished/ healthy and strong 0 1 2 3 4 5

Mental/Emotional/Spiritual

1. Make time to participate in things you enjoy? 0 1 2 3 4 5
2. Give and receive affection regularly 0 1 2 3 4 5
3. Feel gratitude daily 0 1 2 3 4 5
4. Find meaning in life during difficult times 0 1 2 3 4 5
5. Treat yourself with kindness 0 1 2 3 4 5
6. Remember to make your dreams and goals a priority 0 1 2 3 4 5

Professional/Work/Career

1. Hold a work position in areas of interest? 0 1 2 3 4 5
2. Find a sense of meaning and enjoyment at work 0 1 2 3 4 5

15. Have confidence in your ability to address challenges at work 1 2 3 4 5

16. Feel supported at work or professional life? 0 1 2 3 4 5

17. Set limits at work, whether it be with clients or tasks? 0 1 2 3 4 5

18. Disengage and leave pressures behind at the end of the day 0 1 2 3 4 5

Social/Family/ Relationships

19. Have supportive family and friends 0 1 2 3 4 5

20. Participate in activities with people who make you happy 0 1 2 3 4 5

21. Spend time with people who share a common interest 0 1 2 3 4 5

22. Have a dependable person who is loving and listens to you 0 1 2 3 4 5

23. Feel comfortable saying no 0 1 2 3 4 5

24. Do something fun with family or friends once a week 0 1 2 3 4 5

25. Feel personal life and professional life are in balance 0 1 2 3 4 5

26. Feel comfortable asking for help when you need it 0 1 2 3 4 5

**Dental History**

Yes No Yes No

Problem with sore gums Bleeding gums

Metallic taste in mouth Bad Breath (Halitosis)

Problems chewing Tooth pain

Floss regularly Gingivitis

Do you have amalgam fillings? \_\_\_\_\_\_\_yes \_\_\_\_\_\_\_no How many? \_\_\_\_\_\_\_\_Gold fillings \_\_\_\_\_\_\_yes \_\_\_\_\_no

How many? \_\_\_\_

Do you have root canals? \_\_\_\_\_\_\_yes\_\_\_\_\_\_no How many? \_\_\_\_\_\_\_\_\_Implants? \_\_\_\_\_\_\_Yes\_\_\_\_\_\_\_\_\_\_\_No

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**Family History** (please list any cardiovascular, thyroid, diabetes, autoimmune, cancers, addictions, mental health)

Age Living Age Death Health Problems

Mother

Maternal Grandmother

Maternal Grandfather

Father

Paternal Grandmother

Paternal Grandfather

Maternal Aunts

Maternal Uncles

Paternal Aunts

Paternal Uncles

Siblings

Spouse

Children

**Review of Systems** (please circle Yes (Y) if condition you have now or in the past 6 months No (N) never had or Past (P) if in the past longer than 6 months ago)

Cold hands and feet Y N P Numbness Y N P Headache Y N P

Daytime sleepiness Y N P Tingling Y N P Migraine Y N P

Difficulty falling/staying Loss of Memory Y N P Tension Headache Y N P

Asleep Y N P Vértigo/Dizziness Y N P Head Injury Y N P

Early wakening Y N P Loss of balance Y N P Concussion Y N P

Fever Y N P Fainting Y N P Jaw/TMJ problems Y N P

Flushing Y N P Lightheadedness Y N P Eye Conjunctivitis Y N P

Sleepwalking Y N P Loss of consciousness Y N P Eye crusting Y N P

Nightmares Y N P Nerve Pain Y N P Impaired vision Y N P

No Dream Recall Y N P Tremor Y N P Eye Pain/Strain Y N P

Snoring Y N P Rash Y N P Glasses/contact Y N P

Chronic Fatigue Y N P Eczema Y N P Tearing or dryness Y N P

Chronic Infection Y N P Hives Y N P Double Vision Y N P

Enlarged lymph nodes Y N P Acne Y N P Glaucoma Y N P

Slow wound Healing Y N P Boils Y N P Cataracts Y N P

Chemical/Metal

Drug Poisoning Y N P Itching Y N P Muscle Twitch Eye Y N P

Hot/Cold Intolerance Y N P Perpetual hair loss Y N P Impaired hearing Y N P

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Night Sweats Y N P Cellulite Y N P Ringing or Noise Y N P

Hyper/Hipoglicemia Y N P Dark Circles under eyes Y N P Earaches Y N P

Excess Thirst/Hunger Y N P Ear/Face Red (circle) Y N P Dizziness Y N P

Fatigue Y N P Moles color/size change Y N P Ear fullness Y N P

Agoraphobia Y N P Oily/ pale skin (circle) Y N P Other ear pain Y N P

Auditory/Visual Sensitive to bites Y N P Sensitive to loud

Hallucinations Y N P Shingles Y N P Noise Y N P

Treatment for Emotional Skin darkening Y N P frequent sore

Problem Y N P Strong body odor Y N P Throats Y N P

Difficulty concentrating Y N P Thick Calluses Y N P Excess saliva Y N P

Mood swings Y N P Vitiligo Y N P Dry mouth Y N P

Memory Problems Y N P Nails bitten Y N P Teeth grinding Y N P

Depression Y N P Nails Brittle Y N P Hoarseness Y N P

Anxiety/Nervousness Y N P Nails curved/frayed Y N P Sore Tongue Y N P

Panic Attacks Y N P Nail Fungus Y N P Coating on tongue Y N P

Fearfulness Y N P Nail Pitting Y N P Loss of taste Y N P

Irritability Y N P Nail thickening/ridges Y N P Canker/Cold Sores Y N P

Phobias Y N P Ragged Cuticles Y N P Cracking at Corner

Paranoia Y N P White spots/lines Y N P of lips Y N P

Seizures Y N P Paralysis Y N P Dentures Y N P

Muscle weakness Y N P neck lumps Y N P Swollen Glands Y N P

Goiter/enlarged thyroid Y N P Neck pain/ Stiffness Y N P Nose Stuffiness Y N P

Sinus fullness Y N P Anal Spasm Y N P Urethra Pain Y N P

Nose bleeds Y N P Anal Fissures Y N P Urethra Irritation Y N P

Loss of smell Y N P Trouble swallowing Y N P Urethral Itching Y N P

Sinus infection Y N P heartburn Y N P Vaginal discharge Y N P

Postnasal drip Y N P Nausea Y N P Vaginal odor Y N P

Bad Breath Y N P Vomiting Y N P Vaginal Itching Y N P

Dry/Productive Cough Y N P Blood in stool Y N P Vaginal Pain Y N P

Spitting up blood Y N P Mucous in stool Y N P Endometriosis Y N P

Wheezing Y N P Constipation Y N P Fibroids Y N P

Allergies Y N P Diarrhea Y N P Ovarian Cysts Y N P

Asthma Y N P Pain or abdominal cramping Y N P Sexually active Y N P

Bronchitis Y N P Gallbladder disease Y N P Low Libido Y N P

Pneumonia Y N P Belching Y N P Sexual difficulty Y N P

Pleurisy Y N P Gas Y N P

Emphysema Y N P Bloating Y N P Pain during

Pain on breathing Y N P Ulcer Y N P Intercourse Y N P

Shortness of Breath Y N P Jaundice (yellow skin) Y N P Sexually transmitted

Positive TB Test Y N P Hemorrhoids Y N P Diseases Y N P

Heart disease Y N P Liver Disease Y N P Irregular Cycles Y N P

Angina Y N P Pain on urination Y N P Bleeding between

High Blood pressure Y N P Burning on urination Y N P Cycles Y N P

Low Blood Pressure Y N P Increased Frequency Y N P Painful Menses Y N P

Murmurs Y N P Frequent urination at night Y N P Clots Y N P

Irregular Pulse Y N P Incontinence Y N P Difficulty

Blood clots Y N P Bedwetting Y N P Conceiving Y N P

Chest Pain Y N P Hesitancy Y N P Breast Lumps Y N P

Phlebitis Y N P Frequent Infection Y N P Breast Cysts Y N P

Palpitations/ Fluttering Y N P Kidney Disease Y N P Breast Pain/

Rheumatic Fever Y N P Kidney Stones Y N P Tenderness Y N

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Swelling in Knees/ ankles Blood in urine Y N P Nipple Discharge Y N P

Feet (circle) Y N P Bladder Pressure Y N P Muscle Spasm Y N P

Stroke Y N P Urine Odor Y N P Joint Pain Y N P

Valve Prolapse Y N P Easy Bleeding/ Bruising Y N P Joint Stiffness Y N P

Anemia Y N P Deep Leg Pain Y N P Joint Deformity Y N P

Cold Hands/Feet (circle) Y N P Varicose Veins Y N P Joint Redness Y N P

Thrombophlebitis Y N P Arthritis Y N P Broken Bones Y N P

Muscle Weakness Y N P Muscle Cramps Y N P Muscle Pain Y N P

Muscle Stiffness Y N P Back Pain Y N P Tendonitis Y N P

Food Intolerance Y N P

* Lactose Y N P
* Gluten Y N P
* Corn Y N P
* Eggs Y N P
* Fatty Food Y N P
* Yeast Y N P

Additional Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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