Health & Wellness Questionnaire

GENERAL INFORMATION

Name _____ Gender: M F Today's date / /

E-Mail Address

Street Address City ST Zip

Phone #: Home Work Cell Marital Status: S M D W Sep

Date of Birth / / Allergies: Do you smoke (PPD)? _____-

Occupation Employer

Living Situation: ❑Alone ❑Friend(s) ❑Partner ❑Spouse ❑Parents ❑Children #of children: _____ ❑Pets

Physician #1

Physician #2 Other Holistic Care Provider(s)

How did you hear about Dr. Rosenbaum's consulting practice?

❑ Physician or Health Professional Referral (please specify) _____ ❑ Public Presentation

❑ Brochure/Newsletter ❑ Family/Friend ❑ Phone Book ❑ Health Fair ❑ Mailing ❒ Radio Show ❒ Website

Primary Reason for today's visit?

Total cholesterol & LDL cholesterol blood levels _____, vitamin D blood level _____, Dexascan test reading_____, fasting blood sugar level _____, blood pressure reading _____, PSA level (men) _____ (include dates for all if known please).

PAST MEDICAL HISTORY

Please list any surgeries you have had.

AREAS OF PAIN OR DISCOMFORT

❑ Head ❑ Neck ❑ Shoulders ❑ Arms or Legs ❑ Back ❑ Hips ❑ Knees ❑ Other _____

MEDICATIONS Please list any medications you are taking now, including over the counter medicine, herbs, vitamins, dietary supplements, protein powders, birth control pills, eye drops, topical products, etc.

STRESS & RELAXATION Please list any areas of stress in your personal or work life.

Where do you hold stress in your body?

What do you do to relax (hobbies, meditate, read, exercise, music)?

Do you have any spiritual concerns? _____

Do you have a faith community (yes/no; denomination)? _____

How much time do you like to spend in nature each week?

GOALS What are your personal goals for your health and wellness?