Wholey Healing
www.wholeyhealing.com
**Dr. Philip W. Faler, N.D.**
*Natural and Integrative Health Care for Your Whole Family*

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# PATIENT INTAKE AND HEALTH HISTORY

- Please complete this "Intake" and health history as thoroughly as possible
- The form is used to learn about your unique health care needs.
- Print all information and mark anything you don't understand with a question mark
- Please attach a list of any medications or natural supplements you take and list them in the following format:

Name of Medication/Supplement Dose How Often Prescribed by (Doctor or Self)

Name_____

Date_____

Age_____ Date of Birth_____ Sex F M Occupation_____

SS#_____

Address_____

_____

City_____ State_____ Zip

Code_____

Telephone No.

(Home)_____(Work)_____

Email

Address_____

Marital Status: Divorced____ Married____ Partners____ Separated____ Single____ Widowed____

Live with: Alone_____ Children_____ Friends_____ Parents_____ Partners_____ Relatives_____ Spouse_____

**In Case of Emergency, please notify:**

Name_____

Relationship_____

Address_____

_____

City_____ State_____ Zip

Code_____

Telephone No.

(Home)_____(Work)_____

When and where did you last receive medical or health

care?_____

_____

_____

What was the

reason?_____

What are your most important health problems? List in order of importantce.

1.

_____

___

2.

_____

___

3.

_____

___

4.

_____

___

5.

_____

___

* * * * * * * * * Please Remember to Attach Your List of Medications/Supplements * * * * * * * * *

For each of the following, please circle Y, P, or N.

Y = Yes for a condition you have Now. P = A condition you have had in the Past. N = Never have had.

**GENERAL INFORMATION**

Weight :_____

Weight 1 year ago_____

Maximum weight:_____

When:_____

Height

Fatigue Y P N

**SKIN**

Rashes Y P N

Eczema Y P N

Hives Y P N

Acne Y P N

Boils Y P N

Itching Y P N

Color change Y P N
Lumps Y P N
Night sweats Y P N

**HEAD**

Headaches Y P N
Head injury Y P N

**EYES**

Impaired vision Y P N
Glasses or contacts Y P N
Eye pain Y P N
Tearing or dryness Y P N
Double vision Y P N
Glaucoma Y P N
Cataracts Y P N

**EARS**

Impaired hearing Y P N
Ringing Y P N
Earache Y P N
Dizziness Y P N

**NOSE AND SINUSES**

Frequent colds Y P N
Nose bleeds Y P N
Stuffiness Y P N
Hay fever Y P N
Sinus problems Y P N

**MOUTH/THROAT**

Frequent sore throat Y P N
Sore tongue Y P N
Gum problems Y P N
Hoarseness Y P N
Dental cavities Y P N

**NECK**

Lumps Y P N
Swollen glands Y P N
Goiter Y P N

**RESPIRATORY/BREATHING**

Cough Y P N
Sputum Y P N
Spitting up blood Y P N
Wheezing Y P N
Asthma Y P N
Bronchitis Y P N
Pneumonia Y P N
Pleurisy Y P N

Difficulty breathing Y P N
Pain on breathing Y P N
Shortness of breath Y P N
" " at night Y P N
" " lying down Y P N
Tuberculosis Y P N

**CARDIOVASCULAR (HEART)**

Heart disease Y P N
Angina Y P N
High blood pressure Y P N
Murmurs Y P N
Rheumatic fever Y P N
Chest pain Y P N
Swelling in ankles Y P N
Palpitation, flutters Y P N

**GASTROINTESTINAL (DIGESTION)**

Trouble swallowing Y P N
Heartburn Y P N
Change in thirst Y P N
Change in appetite Y P N
Nausea Y P N
Vomiting Y P N
Vomiting blood Y P N
Blood in stool Y P N
Belching or pass gas Y P N
Jaundice (yellow skin) Y P N
Liver disease Y P N
Gall bladder disease Y P N
Ulcer Y P N
Hemorrhoids Y P N
Bowel movements:
How often?_____
Is this a change?_____

**URINARY**

Pain on urination Y P N
Increased frequency Y P N
Frequency at night Y P N
Inability to hold urine Y P N
Frequent infections Y P N
Kidney stones Y P N

**FEMALE REPRODUCTION**

Age menses began_____
Average number of days_____
Length of cycle_____
Bleeding between periods Y P N

Are cycles regular Y P N
Pain during intercourse Y P N
Painful menses Y P N
Excessive flow Y P N
Birth control Y P N
What type? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Difficulty conceiving Y P N
Menopausal symptom Y P N
Are you sexually active Y P N
Sexual difficulties Y P N
Venereal disease Y P N
Discharge or sores Y P N

**Breasts**

Do you self exam Y P N
Lumps Y P N
Pain (or tenderness) Y P N
Nipple discharge Y P N

**MALE REPRODUCTION**

Hernias Y P N
Testicular masses Y P N
Testicular pain Y P N
Are you sexually active Y P N
Sexual difficulties Y P N
Prostate disease Y P N
Venereal disease Y P N
Discharge or sores Y P N

**MUSCULOSKELETAL**

Joint pain or stiffness Y P N
Arthritis Y P N
Broken bones Y P N
Muscle spasms or cramps Y P N
Weakness Y P N

**PERIPHERAL VASCULAR**

Deep leg pain Y P N
Cold hands/feet Y P N
Varicose veins Y P N
Thrombopphlebitis Y P N

**NEUROLOGICAL (NERVOUS SYSTEM)**

Fainting Y P N
Seizures Y P N

Paralysis Y P N
Muscle weakness Y P N
Numbness or tingling Y P N
Loss of memory Y P N

**EMOTIONAL**

Depression Y P N
Mood swings Y P N
Anxiety or nervousness Y P N
Tension Y P N

**ENDOCRINE**

Hypothyroid Y P N
Heat or cold intolerances Y P N
Excessive thirst Y P N
Excessive hunger Y P N

**BLOOD**

Anemia Y P N
Easy bleeding or bruising Y P N

**Lifestyle/Habits**

What are your main interests or hobbies?

_____

_____

Do you exercise? Y P N

What kinds_____

_____

_____

How often_____

Do you eat three meals daily Y P N
Awaken rested Y P N
Sleep well Y P N
Average 6-8 hours sleep Y P N
Enjoy your work Y P N
Spend time outside Y P N
Watch television Y N How many hours a day_____
Read Y N How many hours a day_____
Take vacations Y P N
Been treated for drug dependence Y P N
Use recreational drugs Y P N
Use alcoholic beneverages Y P N
Been treated for alcoholism Y P N
Use tobacco Y N How much_____How long_____

## Family History

| Check those Applicable: | Father | Mother | Brothers | Sisters | Spouse | Child |
|---|---|---|---|---|---|---|
| Age (if living) | _____ | _____ | _____ | _____ | _____ | _____ |
| Health: G =Good, P =Poor | _____ | _____ | _____ | _____ | _____ | _____ |
| Cancer | _____ | _____ | _____ | _____ | _____ | _____ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Diabetes | _____ | _____ | _____ | _____ | _____ | _____ |
| Heart Disease | _____ | _____ | _____ | _____ | _____ | _____ |
| High Blood Pressure | _____ | _____ | _____ | _____ | _____ | _____ |
| Stroke | _____ | _____ | _____ | _____ | _____ | _____ |
| Epilepsy | _____ | _____ | _____ | _____ | _____ | _____ |
| Mental Illness | _____ | _____ | _____ | _____ | _____ | _____ |
| Asthma, Hayfever, Hives | _____ | _____ | _____ | _____ | _____ | _____ |
| Anemia | _____ | _____ | _____ | _____ | _____ | _____ |
| Kindey Disease | _____ | _____ | _____ | _____ | _____ | _____ |
| Glaucoma | _____ | _____ | _____ | _____ | _____ | _____ |
| Tuberculosis | _____ | _____ | _____ | _____ | _____ | _____ |
| Age (at death) | _____ | _____ | _____ | _____ | _____ | _____ |
| Cause of death | _____ | _____ | _____ | _____ | _____ | _____ |

FOR THE FOLLOWING SELECTIONS, PLESAE CIRCLE: Y = YES, or N = NO

## Childhood Illnesses History

Scarlet fever Y N Diphtheria Y N Rheumatic fever Y N

Mumps Y N Measels Y N German Measles Y N

Other

_____

## Immunization History

Polio Y N Pertussis Y N

Tetanus (not antitoxin) Y N Diphtheria Y N

Measles/Mumps/Rubella Y N Other

_____

## Hospitalization and Surgery

Please list hospitalizations and surgeries you have had:

_____

_____

_____

_____

_____

## X-rays and Special Studies

X-rays, CAT scans, or MRI's you have had:

_____

_____

_____

_____

Electrocardiogram (EKG) Y N Electroencephalogram (EEG) Y N

## Allergies:

Please list foods, drugs, or other allergies:

_____

_____

_____

_____

* * * * * * * * * Please Remember to Attach Your List of Medications/Supplements * * * * * * * * *