Watson Wellness Intake Form

Patient Name: _____ DOB: _____ Date: _____

Height: _____ Weight: _____ Age: _____

Please complete the following information in detail. This will assist us in designing the most effective and efficient individualized program for you. Every item is significant. Please print neatly.

Who recommended you to this clinic?

_____

Official Diagnosis/Main Problem:

_____

List main complaints/challenges in order of importance:

_____

_____

When did pain begin (weeks/months/years):

_____

Describe current area of pain AND type of pain (aching, numbness, tingling, burning: _____

_____

_____

What makes pain worsen:

_____

_____

What makes pain decrease:

_____

_____

Special tests (X-rays, MRIs, etc.):

_____

_____

List current medications and dosages: _____

_____

_____

_____

Additional Treatments: _____

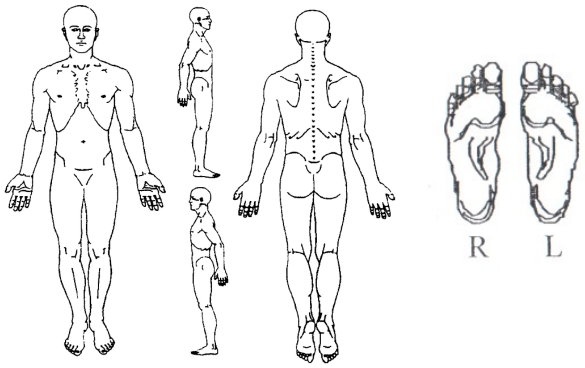
_____

_____

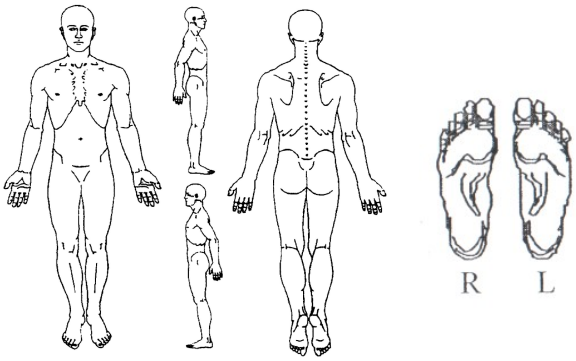
Circle the level of pain you are experiencing on a scale of 1-10 (1=lowest):

1 2 3 4 5 6 7 8 9 10

Pain Diagram: Please shade in all areas of pain:



Parasthesia Diagram: Please shade areas of "funny feeling" (tingling, burning, pins and needles, etc):



Please tell us about your additional symptoms by checking the appropriate boxes:

- € Dizziness
- € Fainting
- € Decreased concentration
- € Memory loss
- € Slurred speech
- € Balance problems
- € Headaches
- € Difficulty swallowing
- € Ears: ringing, stuffy, painful
- € Sore that does not heal
- € Nagging cough/hoarseness
- € Sexual function problems
- € Vision: blurring, burning, aching, pressure, change, dbl
- € Drooping eyelid or any changes in your pupils
- € Unusual bleeding or discharge
- € Change in any wart or mole
- € Thickening in breast/elsewhere
- € Pain that wakes you from a sound sleep
- € Bowel problems
- € Stiffness
- € Cold feet
- € Cold hands
- € Chest pain
- € Sinus problems
- € Snoring
- € Nausea
- € Indigestion
- € Night sweats
- € Allergies

Health History (List and explain. Include dates and treatments received)
Surgeries:_____
_____
_____

Injuries:_____
_____
_____

Major/Minor Illnesses:_____
_____
_____

Any history of falls in the last year:_____
_____

Present Activity
How many hours do you sleep at night:_____

How many hours per day do you spend in bed:_____

How would you rate your present level of activity:
€ Poor € Fair € Good

Please list your present hobbies:_____
_____

Current Work Status and History
Please state what you do for a living:_____
_____

How many hours do you work per week:_____

If not working, how long have you not worked:_____

Are you not working for reasons other than your pain/problem?
If so, what reason?_____
_____

Are you a full time homemaker: Yes No

Do you receive compensation (disability insurance): Yes No

If not, are you considering or have you applied for compensation of any kind:_____

If you anticipate returning to work, when do you hope to do so:
_____

Home Environment
Please list any current assistive devices (cane, walker, etc):
_____

Present home environment (railings, ramps, bathroom modifications, etc):_____
_____

Vaccination/Inoculations
When was your last vaccination/inoculation:_____
_____

When have you traveled out of the country:_____
_____
Did this require inoculation: Yes No
Did you become ill: Yes No

Are you losing weight without trying: Yes No

Are you coughing up blood/noticing it in urine/stool:
Yes No

Have you lost consciousness/had double vision recently:
Yes No

Health Habits
€ Tobacco € Alcohol € Caffeine € Soda

How often do exercise per week:_____

Average duration of your workouts:_____

What type of activities do you do for exercise (run, bike, swim, weights, etc.):_____
_____

Nutrition and Diet:
€ Vegetarian € Vegan € High Protein € Salt Restriction
€ Low Fat Diet € The Zone Diet
€Startch/Carbohydrate Restriction € Atkins Diet
€ Other_____

Specific Food Restrictions:
€ Dairy € Soy € Eggs € Corn € All Gluten
€ Wheat € Sugar € Other_____

Circle the level of stress you are experiencing on a scale of 1-10 (1=lowest):
1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (changes in job, work, residence or finances, legal problems):
_____
_____

List any prescribed over the counter medications and/or supplements your are taking:
_____
_____
_____

While you are here at Watson Wellness a goal list will help us recognize what you would like to accomplish. Your therapist will evaluate you with your input in mind. Goals will be revised as needed. Please fill in the blanks below, answering the question
"I know I will be better when I can…."
1._____
2._____
3._____

Current and Past Medical History – Check all that apply

- o Alcoholism
- o Allergies
- o Alzheimer's Disease
- o Arthritis
- o Asthma
- o Attention Deficit Disorder (ADD)
- o Attention Deficit Hyperactivity Disorder (ADHD)
- o Autoimmune Disease type_____
- o Back Pain
- o Bronchitis
- o Cancer type_____
- o Carpal Tunnel Syndrome
- o Cerebral Palsy
- o Cholesterol (elevated)
- o Chronic Fatigue Syndrome
- o Circulatory Problems
- o Colitis
- o Dental Problems
- o Depression
- o Diabetes
- o Diverticular Disease
- o Drug Addiction
- o Eating Disorder
- o Epilepsy
- o Environmental Sensitivities
- o Eyes/ears/nose/throat problems
- o Facial Palsy
- o Fibromyalgia
- o Food Intolerance
- o Gastrointestinal Problems
- o Genetic Disorder type_____
- o Glaucoma
- o Gout
- o Headaches
- o Heart Disease
- o High Blood Pressure
- o Infection, chronic
- o Inflammatory Bowel Disease
- o Irritable Bowel Syndrome
- o Kidney or bladder disease
- o Learning Disabilities
- o Liver or gallbladder disease (stones)
- o Lymphedema
- o Lymphatic Problems
- o Mental Illness
- o Mental Retardation
- o Migraine Headaches
- o Mononucleosis
- o Multiple Sclerosis
- o Musculoskeletal problems
- o Obesity
- o Osteoporosis
- o Paraplegia
- o Parkinson's
- o Phobias
- o Pneumonia
- o Quadriplegia
- o Respiratory problems
- o Rheumatoid Arthritis
- o Seasonal Affective Disorder
- o Sinus Problems
- o Skin Problems
- o Spina Bifida
- o Stroke
- o Thyroid Disease/Trouble
- o Traumatic Brain Injury (TBI)
- o Tuberculosis
- o Ulcer
- o Urinary Tract Infection
- o Varicose Veins
- o Other

Medical (Men):

- o Benign Prostatic Hypertrophy
- o Decreased sex drive
- o Infertility
- o Prostate Cancer
- o Sexually Transmitted Disease
- o Other_____

Medical (Women):

- o Breast Cancer
- o Breast surgery/reduction/ Implants
- o Decreased sex drive
- o Endometriosis
- o Fibrocystic breasts
- o Fibroids/ovarian cysts
- o Infertility
- o Menstrual irregularities
- o Date of onset of last menses_____
- o Pelvic Inflammatory Disease
- o PMS
- o Sexually transmitted disease
- o Vaginal Infections
- o Other

List daily activities limited by condition:_____