

# Welcome Back to Angelic Wellness! Please update your records

Date \_\_\_\_\_ file # \_\_\_\_\_

Name(First, middle, last) \_\_\_\_\_

What do you prefer to be called? \_\_\_\_\_

Mailing address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

e-mail \_\_\_\_\_

Alternative address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

SS# \_\_\_\_\_ Occupation or what you retired from \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Marital Status \_\_\_\_\_ Gender MALE FEMALE

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_

Spouse or Emergency Contact Name (circle one) \_\_\_\_\_

Phone \_\_\_\_\_

Angelic Wellness is considered a cash practice in that we expect payment in full at the time of service. We will submit your insurance for you and will do the best we can to get you paid. However, ultimately you are responsible for paying for your care and getting your insurance company to pay you.

Insurance Carrier \_\_\_\_\_

Please give us your insurance card and photo ID if you want us to submit to your insurance carrier.

Do you consider this condition to be (please circle one)

Chronic condition Congenital problem Acute (new) issue Date problem started \_\_\_\_\_

**To serve you to the best of our ability, we need to know as much about you as possible.**

**Please take the time to fill in your information. It really is that important!**

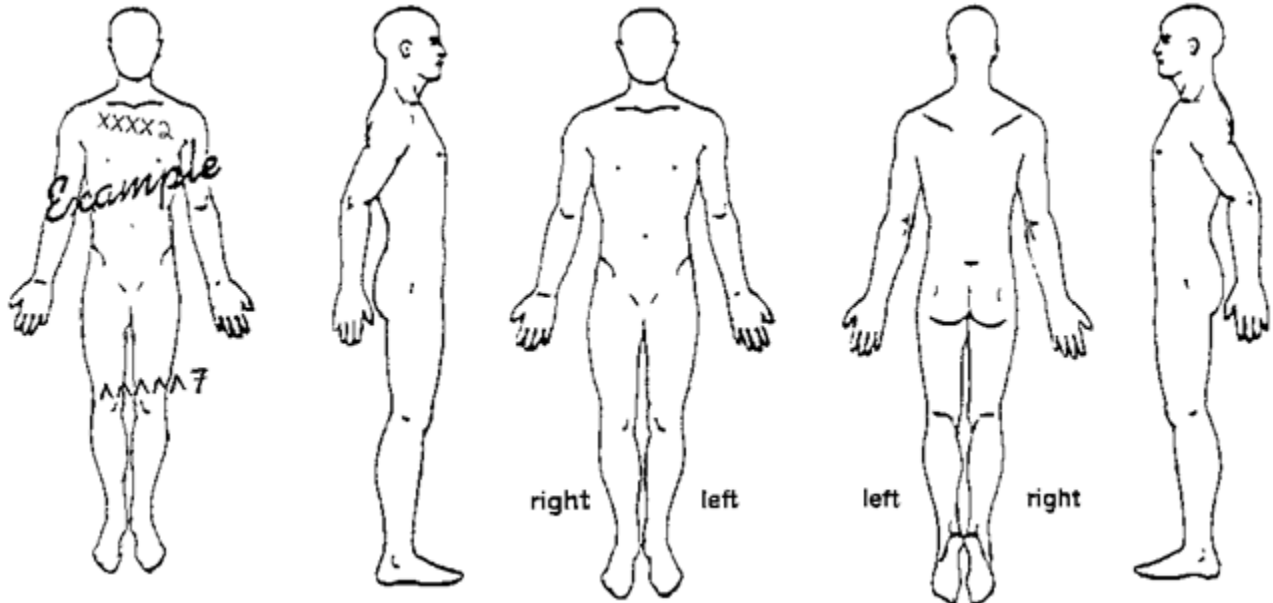
What are your health and wellness goals? \_\_\_\_\_

**If you are here for wellness and have no complaints, please forgive the questions that do not pertain to you.**



Please show us where you are experiencing symptoms...  
 Indicate your degree of pain using a scale of 1 (minor discomfort) to 10 (extreme pain):

Numbness      Pins & Needles      Burning      Aching      Stabbing  
 - - - - -      0 0 0 0 0 0      ^ ^ ^ ^ ^      X X X X      / / / / / / /



Has your condition caused you to lose enjoyment in (Circle all that apply)  
 Hobbies      Personal Activities      Sports      Work

Has your condition caused you duress in work or school?    YES    NO

Has your condition caused you duress in your household duties?    YES    NO

If you have lost time from school or work due to this condition, how much? \_\_\_\_\_

**Activities of Daily Living**

Please circle any of the following that you are not doing as well as you feel you should.

- Bathing      driving      getting in and out of car      caring for children      lifting children
- Playing with children      computer      dressing      eating      feeding self      grooming
- Cleaning      cooking      dishes      laundry      yard work      managing finances
- Managing medications      oral care      paperwork      caring for pet/s      phone
- Reading      religious events      sex      shopping      sitting      sleeping      social activities
- Stairs      standing      toileting      walking      working      writing
- Other \_\_\_\_\_

For each of the above that you have circled, please place a number next to it indicating how severe  
 1 mild      2 mild to moderate      3 moderate      4 moderate to severe      5 severe

**Medications** currently taking (we are happy to make a copy of any list that you carry☺)

\_\_\_\_\_

Please list any **medical or psychological** issues you are being treated for \_\_\_\_\_

\_\_\_\_\_

Please list any **surgeries, hospitalizations or injuries** you have had \_\_\_\_\_

\_\_\_\_\_

Please list any **herbs, vitamins, home remedies, homeopathic remedies** \_\_\_\_\_

\_\_\_\_\_

**Marital Status**    single        married        widowed        divorced        other

**Alcohol Use** (How much?)

Beer                    \_\_\_\_\_        a day        a week        a month        a year

Wine                    \_\_\_\_\_        a day        a week        a month        a year

Liquor                   \_\_\_\_\_        a day        a week        a month        a year

**Tobacco Use** (How much?) N/A \_\_\_\_\_    Cigarettes \_\_\_\_\_    Cigars \_\_\_\_\_    Chewing tobacco \_\_\_\_\_    Pipe \_\_\_\_\_

**Liquids Consumed** (how much per day?)

Water \_\_\_\_\_        Reg. Coffee \_\_\_\_\_        Decaf. Coffee \_\_\_\_\_        Energy Drinks \_\_\_\_\_

Tea, Black \_\_\_\_\_        Tea, Decaf. \_\_\_\_\_        Tea, Green \_\_\_\_\_        Tea Herbal \_\_\_\_\_

Diet Soda \_\_\_\_\_        Regular Soda \_\_\_\_\_

On a typical day, **what do you eat** for the following meals

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

How many hours do you typically **sleep** each night \_\_\_\_\_

**Exercise** routine including hours per week \_\_\_\_\_

\_\_\_\_\_

**Constitution:**    lack of appetite    fatigue    fever    weight stable    weight loss    weight gain

**Eyes/Head:**    blurred vision    corrective lenses    dizziness    double vision    eye discharge    eye pain  
headache    lightheaded    visual changes    visual disturbance    other \_\_\_\_\_

**ENT/Upper respiratory:**    allergy    bad breath    bridges    dental implants    dentures  
difficulty swallowing    ear pain    ear infection    ear discharge    ears ringing    goiter    hearing loss  
lightheaded    mouth pain    mouth sore    nose discharge    nosebleed    sinus congestion  
sinus issues    sinus pain    snoring    sore throat    loss of teeth    other \_\_\_\_\_

**Cardiovascular:** asthma chest pain cough difficulty breathing difficulty lying flat fainting spells heart problems history of heart disease mucus with color murmur palpitations problems with cholesterol levels shortness of breath with exertion swelling/edema in extremities swollen ankles varicose veins other\_\_\_\_\_

**Respiratory:** bronchitis chills cough coughing blood emphysema lung disease smoking wheezing other\_\_\_\_\_

**Gastrointestinal:** abdominal pain bloody stool change in BMs constipation diarrhea heartburn/reflux hemorrhoids hernia indigestion jaundice nausea vomiting other\_\_\_\_\_

**Genitourinary:** abnormal discharge bladder infection bladder leakage childbirth discharge from penis hysterectomy incontinence jaundice kidney infection kidney pain kidney stones miscarriage pregnancy abnormal pregnancy prostate enlarged prostate symptoms STDs urinate more than twice a night unusual discharge or bleeding frequent urination loss of control of urination painful urination Blood in urine urine clear urine yellow other\_\_\_\_\_

**Musculoskeletal:** arthritis backache cramps headaches joint pain limited motion muscle pain muscle weakness neck pain sore muscles sports injuries muscle stiffness swelling in joints other\_\_\_\_\_

**Skin and Breast:** acne breast discharge breast lumps breast painful change in skin color change in hair change in nails change in skin texture dermatitis dryness eczema fungal infection growths itchiness lumps pimples psoriasis rashes shingles sores suspicious moles warts yeast infection other\_\_\_\_\_

**Neurological:** concussion convulsions diabetes dizziness fainting head trauma headaches memory loss multiple sclerosis neuropathy numbness paralysis Parkinson's disease pins & needles restless legs seizures tingling tremors unable to move parts of body vertigo visual disturbances weakness other\_\_\_\_\_

**Mental:** anger issues anxiety confusion depression difficult sleeping memory loss mental illness mood swings nervousness sadness tension other\_\_\_\_\_

Do you want us to help you naturally with this condition YES NO

**Endocrine:** ankle swelling diabetes excessive appetite excessive hunger excessive thirst excessive urination fatigue hair loss heat/cold intolerance hysterectomy postmenopausal early signs of menopause significant weight change skin changes thyroid issues weakness Other\_\_\_\_\_

**Hematologic/Lymphatic:** anemia blood clots B12 deficiency easy bruising enlarged glands problems with cholesterol levels sore lymph nodes swelling in extremities other\_\_\_\_\_

**Allergic/Immunologic:** environmental allergies food allergies frequent infections hay fever HIV/AIDS hives lupus medication allergies pet allergy rheumatoid arthritis other\_\_\_\_\_