A Better Way to Fitness & Wellness, LLC

Name_____ Date: _____

Address: _____

Age _____ Date of Birth_____ Sex: F M

Phone # _____ E-Mail: _____

How did you hear about us? _____

What are your main health concerns?

1. _____

2. _____

3. _____

Please indicate if you have experienced any of these symptoms in the last 6 months.
1 – Minor or mild symptoms, rarely occurs 2 – Moderate symptoms, occurs occasionally 3 – Severe symptoms, occurs frequently

0	1	2	3	Belching, bloating or gas within one hour after eating
0	1	2	3	Heartburn or acid reflux
0	1	2	3	Sense of excess fullness after meals
0	1	2	3	Sleepy after meals
0	1	2	3	Stomach pains or cramps
0	1	2	3	Diarrhea shortly after meals
0	1	2	3	Black or tarry colored stools
0	1	2	3	Undigested foods in stool

0	1	2	3	Stomach upset by greasy foods
0	1	2	3	Nausea
0	1	2	3	Dry skin, itchy feet or skin peel on feet
0	1	2	3	Pain under right side of rib cage
0	1	2	3	Hemorrhoids or varicose veins
0	1	2	3	Chronic Fatigue or Fibromyalgia

0	1	2	3	Food Allergies
0	1	2	3	Airborne allergies
0	1	2	3	Sinus congestion, “Stuffy head”
0	1	2	3	Alternating constipation and diarrhea
0	1	2	3	Asthma, sinus infections, stuffy nose

0	1	2	3	Anus itches
0	1	2	3	Feel worse in moldy or musty place
0	1	2	3	Fungus or yeast infections
0	1	2	3	Stools hard or difficult to pass
0	1	2	3	Less than one (1) bowel movement per day
0	1	2	3	Irritable bowel or colitis
0	1	2	3	Blood in stool
0	1	2	3	Cramping in lower abdominal region

0	1	2	3	Calf, foot or toe cramps at rest
0	1	2	3	Frequent fevers
0	1	2	3	Frequent skin rashes and/or hives
0	1	2	3	Pain or swelling in joints
0	1	2	3	Bursitis or tendonitis
0	1	2	3	Feet have strong odor
0	1	2	3	Decreased sense of taste or smell

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0	1	2	3	Tension headaches at base of skull
0	1	2	3	Headaches when out in the hot sun
0	1	2	3	Sunburn easily or suffer sun poisoning
0	1	2	3	Muscles easily fatigued

0	1	2	3	Awaken a few hours after falling asleep, hard to get back to sleep
0	1	2	3	Excessive appetite
0	1	2	3	Crave coffee or sugar in afternoon
0	1	2	3	Sleepy in afternoon
0	1	2	3	Headache if meals are skipped or delayed

0	1	2	3	Muscles become easily fatigued
0	1	2	3	Depressed
0	1	2	3	Nervous or agitated
0	1	2	3	Can hear heart on pillow at night
0	1	2	3	Night sweats
0	1	2	3	Restless leg syndrome
0	1	2	3	Small bumps on back of arms
0	1	2	3	Bleeding gums when brushing teeth

0	1	2	3	Splitting type headache
0	1	2	3	Memory failing
0	1	2	3	Tolerate sugar, feel fine when eating sugar (0= no, 1 = yes)
0	1	2	3	Excessive Thirst
0	1	2	3	Tendency to ulcers or colitis

0	1	2	3	Difficulty falling asleep
0	1	2	3	Slow starter in the morning
0	1	2	3	Headache when exercising
0	1	2	3	Clench or grind teeth
0	1	2	3	Calm on the outside, troubled on the inside
0	1	2	3	Become dizzy when standing up suddenly
0	1	2	3	Arthritic tendencies

0	1	2	3	Intolerable to high temperature
0	1	2	3	Difficult losing weight
0	1	2	3	Mentally sluggish, reduced initiative
0	1	2	3	Easily fatigued sleeping during the day
0	1	2	3	Sensitive to cold, poor circulation (cold hands and feet)
0	1	2	3	Constipation, chronic
0	1	2	3	Excessive hair loss and/or coarse hair
0	1	2	3	Morning headaches, wear off during the day

0	1	2	3	Urine has strong odor
0	1	2	3	Cloudy, bloody or darkened urine
0	1	2	3	Runny or drippy nose
0	1	2	3	Acne (adult)
0	1	2	3	Itchy skin (Dermatitis)

Regarding your medical history - please answer if you have ever experienced the following:

Yes	No	Drug or Alcohol abuse
Yes	No	Hepatitis
Yes	No	Long term use of prescription/recreational drugs
Yes	No	Kidney stones
Yes	No	Gallbladder attacks/removal
Yes	No	Frequent colds or flu (more than 3 times per year)
Yes	No	History of infections (sinus, ear, lung, skin, bladder, kidney)
Yes	No	History of Epstein Barr, Mono, Herpes, shingles, Chronic fatigue syndrome
Yes	No	Crohn's Disease

Please list all medications that you are currently taking – prescription and supplements:

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Please share any other details about your health that you would like us to address at your appointment:

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