New Patient Health Questionnaire for Wellness Services

First Name:_____ Last Name:_____ Date:_____

DOB: _____ Home Phone:_____ Mobile Phone: _____

Email address:_____ Receive email announcements/newsletters/updates/offers?* Y N

*(*Axiva will never sell, lease, or otherwise disclose your email address/personal information.)*

Address:_____

Emergency Contact Name:_____ Relationship:_____ Phone Number:_____

What medical concerns bring you to our office? _____

Marital Status*: (circle)* S M D W Occupation: *(if retired, previous occupation)*_____

If disabled, check here: ☐ Nature of disability_____

Do you exercise routinely? *(circle)* No Yes If *Yes*, what exercise/how often?_____

Have you ever smoked? *(circle)* No Yes Cigar Pipe Cigarettes If *Yes*: #cigarettes/day_____ #yrs._____

If you have never smoked, skip this question: Do you still smoke now? *(circle)* No Yes If *No*, when did you quit? _____

Caffeine: Do you drink *(circle)* caffeinated coffee, teas or sodas regularly? *(circle)* No Yes #/day _____

Tell us a little about your home environment: *(e.g. live alone, with family, single parent, house, apt., etc.)*_____

Medical Information

Allergies: Are you allergic to any drugs?*(circle)* No Yes Please list:_____

Allergies: Are you allergic to any foods?*(circle)* No Yes Please list:_____

Medications *(list all medications you are taking regularly. Include over the counter, herbal or natural remedies.)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Illnesses or Conditions *(list any chronic conditions which you have been diagnosed to have)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had or been diagnosed to have: *(check box by all that apply)*

POTS/Dysautonomia	☐	Heart Disease	☐	Eczema/Psoriasis	☐	Anemia	☐	Depression/Anxiety	☐
Glaucoma	☐	Heart Murmur	☐	Digestive Disorder	☐	Bleeding Disorders	☐	Frequent Infections	☐
Asthma	☐	High Blood Pressure	☐	Lyme Disease/Co-Infections	☐	Bone or Joint Disease	☐	Cancer (type): vjjjgjgjgh	☐
Allergies	☐	Pneumonia	☐	Kidney Disease	☐				
Stroke	☐	TB/COVID-19	☐	Kidney Stone(s)	☐	Chronic Fatigue Syndrome	☐	ADD/ADHD	☐
Seizures/Epilepsy	☐	SIBO	☐	Diabetes or Pre-Diabetes	☐	Migraines	☐	Neuropathy	☐
Heart Attack or Angina	☐	Jaundice or Liver Disease	☐	Eating Disorder	☐	Chronic EBV/HHV-6	☐	Mold/Biotoxin Illness	☐

Patient Name _____

Operations:
Please list any surgery and approximate year

Year	Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations:
Other than operations

Year	Reason	Hospital
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

What are your medical complaints? *(check box by all that apply)*

Fatigue or low energy	☐	Asthma and Allergies	☐
Stress	☐	Recent surgical procedure	☐
Poor diet due to busy lifestyle	☐	Recent illness	☐
Low mood or depression	☐	Cold or flu symptoms	☐
Headaches or migraines	☐	Facial wrinkles or fine lines	☐
Weight gain or difficulty losing weight	☐	Dull or dry skin	☐
Slow metabolism	☐	Malabsorption issues	☐
Decreased or low appetite	☐	Hangover	☐

Weight: What is your current weight? _____

Females Only: Are you pregnant, planning a pregnancy or nursing a child? *(circle)* No ○ Yes ○

Have you previously received any of the following treatments or therapies? (Mark all that apply.) If so, please explain any side effects, or other difficulties, you experienced related to the treatment or therapy.

☐ IV Vitamin Therapy: _____
☐ IV Chelation Therapy: _____
☐ Infrared Sauna Therapy: _____
☐ Hyperbaric Oxygen Therapy: _____
☐ Massage Therapy: _____
☐ Acupuncture: _____
☐ Hormone Replacement Therapy: _____
☐ Other: _____

Patient Name _____

Systems Review: Please indicate those items that have been a recurrent or a recent significant change.

Constitutional Symptoms	
Y	N
☐	☐ Good health lately
☐	☐ Unexpected weight change (+/- 10 pounds)
☐	☐ Unusual fatigue or weakness
☐	☐ Frequent headaches
Eyes	
☐	☐ Change in vision
☐	☐ Blurred or double vision
☐	☐ Eye disease
☐	☐ Wear glasses/contact lenses
Ears/Nose/Mouth/Throat/Neck	
☐	☐ Do you wear hearing aids?
☐	☐ Hearing loss or ringing in ears?
☐	☐ Chronic sinus problems or runny nose
☐	☐ Nose bleeds
☐	☐ Mouth sores
☐	☐ Bleeding gums
☐	☐ Sore throat/hoarseness or voice change
☐	☐ Lumps or swollen glands in neck
☐	☐ Difficulty swallowing
☐	☐ Neck pain or stiffness
Cardiovascular	
☐	☐ Heart trouble
☐	☐ Chest pain or angina pectoris
☐	☐ Palpitations
☐	☐ Shortness of breath with walking or lying flat
☐	☐ Swelling feet, ankles or hands
☐	☐ Waking at night with shortness of breath
Respiratory	
☐	☐ Chronic or frequent cough
☐	☐ Coughing or spitting up blood
☐	☐ Shortness of breath
☐	☐ Asthma or recurrent wheezing
Gastrointestinal	
☐	☐ Loss of appetite
☐	☐ Change in bowel movements
☐	☐ Nausea or vomiting
☐	☐ Painful bowel movements or constipation
☐	☐ Frequent diarrhea
☐	☐ Rectal bleeding or blood in stool
☐	☐ Stomach/abdominal pains or heartburn
☐	☐ Black or tarry stools
Comments:	

Genitourinary	
Y	N
☐	☐ Frequent urination
☐	☐ Burning or pain on urination
☐	☐ Blood in urine
☐	☐ Change in force or strain when urinating
☐	☐ Incontinence or dribbling of urine
☐	☐ Sexual difficulties
☐	☐ **Men**: Testicular pain
Women: Required only if participating in hormone therapy program	
☐	☐ Painful periods
☐	☐ Irregular periods
☐	☐ Recurrent vaginal discharge
☐	☐ Number of pregnancies:
☐	☐ # Deliveries # of Miscarriages
☐	☐ Method of birth control (if applicable)
☐	☐ Menopausal, since when:
☐	☐ Date of last pap smear:
☐	☐ Date of last mammogram:
Musculoskeletal	
☐	☐ Joint pain(s)
☐	☐ Joint stiffness/swelling or warmth
☐	☐ Weakness of muscles or joints
☐	☐ Muscle pain or recurrent cramps
☐	☐ Back pain
☐	☐ Cold hands or feet
☐	☐ Difficulty in walking
Integumentary (Skin/Breast)	
☐	☐ Rashes or itching
☐	☐ Change in skin color or moles
☐	☐ Change in hair or nails
☐	☐ Varicose veins
☐	☐ Breast pain
☐	☐ Breast lump
☐	☐ Breast discharge or rash
Neurological	
☐	☐ Frequent, recurring or increasing headaches
☐	☐ Light-headedness or dizziness
☐	☐ Convulsions, seizures or spasms
☐	☐ Numbness or tingling sensations
☐	☐ Tremors
☐	☐ Paralysis
☐	☐ Stroke
☐	☐ Head injury

Patient Name _____

Psychiatric		
Y	N	
		Memory loss or confusion
		Anxiety
		Insomnia
		Depression
Endocrine		
		Glandular or hormone problem
		Heat or cold intolerance
		Excessive skin dryness
		Excessive thirst or urination
		Change in hand or glove size
		Slow to heal after cuts or wounds
		Bleeding or bruising tendency
		Recurrent anemia
		Swelling, warmth or tenderness of veins or history of phlebitis

Allergic / Immunologic		
Y	N	
		History of skin reaction or other adverse reaction to:
		Penicillin or other antibiotic – describe reaction
		Morphine, Demerol or other narcotics – describe reaction
		Novocain or other anesthetics – describe reaction
		Aspirin or other pain remedies – describe reaction
		Tetanus antitoxin or other serums
		Iodine, merthiolate or other antiseptic
		Other medications
		Other known food allergies

Comments: _____

_____

_____

_____

_____

_____

_____

How did you hear about us?

☐ Internet ☐ Social Media ☐ Walk-in ☐ Radio ☐ Friend _____

I certify that the information provided by me on this form is, to the best of my knowledge, accurate and complete. I acknowledge that withholding any medical information may increase the risk of harm from any treatment I receive.

Patient Signature: _____ Reviewed by: _____

Date: _____ Date: _____

Please print the completed form and bring with you to your appointment or fax the completed form to 800.334.2252. Do not email your form. Be advised that use of email is inherently insecure. Confidential information, including confidential information and personally identifiable information, transmitted via email or email attachment could be lost, used, or misused.

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