Denise Souza Integrative Wellness

919-600-8840

PLEASE PRINT LEGIBLY All information for office use only.

Date_____ DOB_____ Age_____ (for AO Scan) Birth Gender ____ Weight _____ Height _____

Name_____ Phone _____

Full Address _____

Email (for newsletters and special offers) _____

Occupation_____ How did you hear about us? _____

Emergency contact info _____

Personal goals relating to services _____

Military (past or present) or immediate family member _____

GENERAL HEALTH

Have you been hospitalized?_____When?_____Why? _____

Have you been diagnosed with a major illness/disease? yes___ no___ When?_____What? _____

_____

_____

Explain any kind of medical treatments you are currently receiving. _____

_____

List any medications you are taking and why. _____

_____

_____

List any supplements you are taking and why. _____

_____

List any kind of 'program' you are on. Ex: fasting, weight loss, nutrition, etc. _____

_____

_____

_____

List all allergies. _____

Are you currently pregnant? yes___ no___ How many pregnancies?__full term___miscarriage___abortion___

Did you gain additional weight with each pregnancy? yes___ no___

Did you lose your pregnancy weight with each child? yes___ no___

How often are your bowel movements? _____ Constipation? yes___ no___

Do you have any metal surgical parts in your body? yes___ no___

Do you currently have, or have you had in the past, any of the following: **C** for Current, **P** for Past

____ Abdominal gas/pain
____ Abdominal hernia
____ Acid reflux
____ AIDS/HIV
____ Anal bleeding
____ Anal discomfort/itching
____ Anxiety
____ Anemia
____ Aneurysm
____ Anorexia
____ Appendicitis
____ Arthritis
____ Asthma
____ Atonic colon
____ Autoimmune disorder
____ Bad breath
____ Belching
____ Bloating, general
____ Bloating, after eating
____ Blood pressure high/low
____ Blood sugar high/low
____ Bulimia
____ Cancer: type _____
____ Candida
____ Celiac disease
____ Cholesterol high/low
____ Chronic fatigue
____ Chronic pain
____ Cirrhosis
____ Colitis
____ Congestive heart failure
____ Contagious disease
____ Constipation
____ Cramping
____ Crohn's disease
____ Depression
____ Diabetes
____ Dialysis
____ Diarrhea
____ Diverticulosis
____ Diverticulitis
____ Dizziness
____ Eczema
____ Edema
____ Environmental allergies
____ Epilepsy
____ Epstein-Barr Virus
____ Extreme weight gain/loss
____ Fainting
____ Fatigue after eating
____ Fever/chills
____ Fibromyalgia
____ Fibroid cysts _____location
____ Fissure/fistula
____ Gallstones
____ Headaches/migraines
____ Heart condition
____ Hemorrhoids
____ IBS
____ Indigestion
____ Intestinal perforation
____ Irregular period
____ Kidney disorder
____ Kidney stones
____ Liver disorder
____ Loss of sleep
____ Low libido
____ Lung disorder
____ Lupus
____ Lyme disease
____ Metal toxicity
____ Menopause
____ Mental disorder
____ Nausea
____ Osteopenia
____ Osteoporosis
____ Pacemaker
____ Parasites
____ PMS
____ Polyp
____ Prolapsed colon
____ Prostate disorder
____ Recent surgery
____ Rectal bleeding
____ Renal insufficiencies
____ Seizures
____ Sinus condition
____ Skin condition
____ Spastic colon
____ Sweats
____ Thyroid disorder
____ Ulcer
____ Urinary tract infection
____ Vomiting
____ Other:_____

DIETARY

Are you: Vegan?_____ Vegetarian?_____ Omnivorous?(eat animal protein) _____

Do you want to change?_____To which group?_____Why?_____

Usual breakfast _____

Usual lunch _____

Usual dinner _____

Usual snack _____

List any cravings you have on a regular basis _____

Do you have sensitivities to any of the following?_____Lactose _____casein_____wheat_____gluten

_____nightshade foods_____ additives_____dyes_____MSG_____preservatives_____latex

Have you had any significant physical and/or emotional trauma?_____If yes, please explain. _____

_____

If you have an exercise routine, please explain. _____

Indicate your consumption accordingly.
H-Heavy(5-7 times per week) **M-Moderate**(2-4 times per week) **L-Light**(1 time or less per week) **N-**Never

___ fresh fruit
___ fresh vegetable juice
___ fresh fruit juice
___ smoothies
___ nuts/seeds
___ beans
___ eggs
___ salad
___ raw vegetables
___ water
___ salt
___ organic foods
___ fish___pork___beef___chicken___turkey

___candy
___alcohol
___cooked vegetables
___caffeine (coffee/tea)
___soda
___dairy (milk, cheese, ice cream)
___processed/frozen foods
___flour products (baked goods, pasta, bread)
___fast foods
___sugar
___tobacco
___ antacids
___ peppers___eggplant___potatoes
___tomatoes

OTHER:
How much water do you drink per day? _____ What is the source? _____
Do you drive an electric car? yes ___ no___
Do you live near radio towers, high power lines, sub-station, etc.? yes___ no___
What WI-FI items are in your bedroom? Router? Computer? _____
Where is your cell phone while you sleep? _____
Ever have Lyme disease? yes___ no___ What was the treatment? _____
Ever been exposed to mold? yes___ no___ Explain_____
Any amalgam fillings (silver filings)? yes___ no___ How many? _____
Any root canals? yes___ no___ How many? _____
How many wisdom teeth have been removed? _____
Do you have implants of any kind? (Breast, cheek, etc.) _____

All information provided above is true and complete. I have no expectation of a diagnosis, prescription or cure and service/consultation is NOT a substitute for medical exam, treatment, or diagnosis.

I understand the required 48 hour cancellation notice for all reschedules and cancellations with the only exception being a medical emergency for myself or my immediate family.

Signature_____ Date _____