Denise Souza Integrative Wellness

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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 _____

SYMPTOM SURVEY

Date: **Name:**

Instructions: Score every symptom based on your experience over the past month. Fill in the appropriate score to the left of every symptom. Total each section, with a grand total at the top. If you did not suffer from any symptoms, leave it blank.

All symptoms are based on levels of severity, longevity, and frequency.
1 = **Minor overall**. Basically symptoms are not severe, don't last very long and are infrequent.
2 = **Mild overall**. Noticeably more bothersome than being minor.
3 = **Moderate overall**. Noticeably more bothersome than being mild.
4 = **Severe overall**. Symptoms last long, are intense, and frequent.

Grand Total: 0

CONSTITUTIONAL			Stuffy nose		Burning muscles
	Fatigue (Sluggish, tired		Sneezing		Stiff joints
	Hyperactive (nervous energy)		**TOTAL**		Hypermobile
	Restless (can't relax/sit still)	**MOUTH/THROAT**			Muscle aches
	Daytime sleepiness		Clench teeth		Stiff muscles
	Insomnia at night		Grind teeth		Tics (facial or otherwise)
	Malaise (feeling lousy)		Sore throat		Muscle spasms
	Seizures		Swollen throat		Muscle cramps
	TOTAL		Swelling/burning lip/tongue		**TOTAL**
EMOTIONAL/MENTAL			Gagging/throat clearing	**CARDIOVASCULAR**	
	Depression		Canker sores		Low blood sugar
	Anxiety (fears, uneasiness)		Bleeding gums		Irregular heartbeat
	Mood swings (rapid changes)		Difficulty swallowing		High blood pressure
	Irritability		**TOTAL**		**TOTAL**
	Forgetfulness	**LUNGS**		**DIGESTIVE**	
	Lack of concentration/Brain fog		Wheezing		Heartburn/reflux
	Low sex drive		Chest congestion		Bad breath
	TOTAL		Dry cough		Stomach pains/cramps
HEAD/EARS			Wet cough		Intestinal pains/cramps
	Headache (not migraine)		Shortness of breath		Constipation
	Migraine		**TOTAL**		Diarrhea
	Earache	**EYES**			Bloating *all the time
	Ear infection		Red or swollen eyes		Gas (bloating after eating)
	Ringing in ears		Watery eyes		Nausea
	Itchy ears		Blood shot eyes		Vomiting
	Discharge from ears		Itchy eyes		Painful elimination
	Sensitivity to sound		Dark circles or "bags"		**TOTAL**
	TOTAL		Sensitivity to light	**WEIGHT MANAGEMENT**	
SKIN			Aura	Current weight:	
	Blemishes, acne		**TOTAL**		*Can't lose weight
	Rashes or hives	**GENITOURINARY**			Fluctuating weight
	Eczema or psoriasis		Increased urinary frequency		Food cravings
	"Rosy" cheeks		Painful urination		Water retention
	Flushing		Bladder pain		Binge eating or drinking
	Itchy skin		Bedwetting		Purging (all methods)
	TOTAL		Erectile dysfunction		**TOTAL**
NASAL/SINUS			Breast tenderness	**LIST OTHER SYMPTOMS**	
	Post nasal drip		Hormonal imbalance		Dizziness
	Sinus pain		**TOTAL**		Hair Loss
	Snore	**MUSCULOSKELETAL**			
	Runny nose		Joint pain		