Stillpoint Wellness Center
Patient Intake & Review of System

This is a confidential record and is strictly confidential, and will become part of your medical record. Information contained here will not be released to any person except when you have authorized to do so.

Date of initial visit:

Basic information

Name:	Birth date (MM/DD/YY):	
Street	Apt #, Suite #:	
City:	St:	Zip:
Home phone:	Work phone:	
☐ Male ☐ Female	Email Address:	
Employer:	Occupation:	

Emergency contact

Name:	Relationship:
Home Phone:	Work phone:
How did you find out about our center?	

Other Healthcare Practitioners

Name: Phone #: Specialty/Focus:	Name: Phone #: Specialty/Focus:	Name: Phone #: Specialty/Focus:

Date of the last visit to medical doctor: Are you currently under his/her care? ☐ Yes ☐ No	Please list regular screening tests done by other physicians (blood tests, physical screening tests):

Health concerns in order of importance to you:	
1	
2	
3	
4	
5	
6	
7	

Your Health History							
Date of last physical exam:							
Immunizations:							
☐	Tetanus	☐	Smallpox	☐	DTP (diphtheria, tetanus, pertussis)	☐	MMR (measles, mumps, rubella)
☐	Hepatitis A	☐	Tuberculosis				
☐	Hepatitis B	☐	Influenza (flu shot)	☐	Chickenpox	☐	Polio
☐	Other ( )						
List if any of these caused adverse reactions:							
Childhood illness							
☐ Mumps ☐ Measles ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio							

List any medical conditions that other doctors diagnosed you:		
No.	Diagnosed month/year	Diagnosis
1		
2		
3		
4		

Surgeries		
Year/Month	Type of surgeries	Reasons

Other hospitalizations	
Year/Month	Reason for the hospitalizations

Have you ever had blood transfusion? ☐ Yes ☐ No

History of your medications / Supplements (list your prescribed medications, over the counter medications, and supplements – pain killer, vitamins, herbs, homeopathies etc.)			
Name of the medications	Dosage/Day	Duration	
		Dates started	Date stopped
Name of the supplements	Dosage/Day	Duration	
		Dates started	Date stopped

Please list all the allergies (Foods, medications, supplements, dust, animal etc.)	
Allergens	Reaction to the allergies

Health habits and Personal Safety				
Exercise:				
☐	Sedentary (No exercise or very minimal exercise)			
☐	Mild exercise (Climbing up and down stairs, golf, walk several blocks)			
☐	Regular exercise (work or sports at least x3 per week for more than 30 minutes)			
Diet:				
Are you on diet?			☐ Yes	☐ No
If yes, is it prescribed by your physicians?			☐ Yes	☐ No
How many meals do you eat per day			_____Times	
Do you have any dietary restrictions? (Religious, vegan etc)				
Salt intake		☐ High	☐ Medium	☐ Low
Fat intake		☐ High	☐ Medium	☐ Low
Carbohydrate intake		☐ High	☐ Medium	☐ Low
Protein intake		☐ High	☐ Medium	☐ Low
Do you take caffeinated drinks?				
☐ Never	☐ Coffee	☐ Tea	☐ Coke	☐ Other ( )
How many cups a day?	_____cups／day			
Alcohol:				
Do you drink alcohol			☐ Yes	☐ No
If yes, how many drinks per week?			_____ drinks /week	
Recreational drugs:				
Do you use recreational drugs?			☐ Yes	☐ No

Tobacco:		
Are you exposed to second hand smoke?	☐ Yes	☐ No
Do you use tobacco?	☐ Yes	☐ No
If yes, how many cigarettes per day?	_____ cigarettes / day	
How long have you been smoking?	# of years _____	
If you have quitted smoking, please tell us the year that you quit		
Sex:		
Are you sexually active?	☐ Yes	☐ No
If yes, are you trying to be pregnant?	☐ Yes	☐ No
If not trying to be pregnant, please identify the method of contraception		
Any discomfort or pain with intercourse?	☐ Yes	☐ No
Sleep:		
How may hours of sleep do you usually get a night?	____ hrs	
Do you sleep well?		
Do you wake up refreshed? ☐ Always ☐ Most of the time ☐ Rarely ☐ Never		

Family Health History					
Relationship		If living:		If deceased:	
		Age	Health concerns	Age of death	Cause
Father					
Mother					
Siblings	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				
Sig other					
Children	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				
Paternal grandfather					
Paternal grandmother					
Maternal grandfather					
Maternal grandmother					
Relative ( )					
Relative ( )					
Relative ( )					
Relative ( )					
Relative ( )					

Please indicate anything else that you feel important and relevant to you and your health.

Review of System

- Beside each item, please check Y (Yes), N (No), or P (Past), and if there is other symptoms, please specify what it is
- Please fill in necessary answers to questions

Overall question			
Current weight	Lb		
Weight one year ago	Lb		
Heaviest weight	Lb		
Height			
Fatigue	Y	N	P
Fever/Chill	Y	N	P
Skin			
Rash	Y	N	P
Eczema	Y	N	P
Hives	Y	N	P
Acne or boils	Y	N	P
Itching	Y	N	P
Color changes	Y	N	P
Lumps	Y	N	P
Dryness	Y	N	P
Moistness	Y	N	P
Nail changes	Y	N	P
Changes in mole(s)	Y	N	P
Night sweats	Y	N	P
Skin cancer	Y	N	P
Other			
Neck			
Lumps	Y	N	P
Swollen glands	Y	N	P
Goiter	Y	N	P
Pain or stiffness	Y	N	P
Other			

Head			
Headache	Y	N	P
Head injury	Y	N	P
Dizziness	Y	N	P
Other			
Eye			
Eye pain	Y	N	P
Blurry vision	Y	N	P
Double vision	Y	N	P
Dryness	Y	N	P
Tearing	Y	N	P
Cataracts	Y	N	P
Glaucoma	Y	N	P
Night Blindness	Y	N	P
Bothered by sun	Y	N	P
Itching	Y	N	P
Redness	Y	N	P
Discharge	Y	N	P
Blind spot	Y	N	P
Other			
Nose			
Easy to catch cold	Y	N	P
Nosebleeds	Y	N	P
Stuffiness	Y	N	P
Hay fever	Y	N	P
Sinus problems	Y	N	P
Other			

Ear				**Respiratory**			
Impaired hearing	Y	N	P	Cough	Y	N	P
Earaches	Y	N	P	Sputum/Phlegm	Y	N	P
Dizziness	Y	N	P	Wheezing	Y	N	P
Discharge	Y	N	P	Asthma	Y	N	P
Infections	Y	N	P	Bronchitis	Y	N	P
Other				Pneumonia	Y	N	P
Mouth and throat				Emphysema	Y	N	P
Frequent sore throat	Y	N	P	Difficulty breathing	Y	N	P
Sore tongue or mouth	Y	N	P	Pain on breathing	Y	N	P
Gum problems	Y	N	P	Shortness of breath	Y	N	P
Hoarseness	Y	N	P	Tuberculosis	Y	N	P
Dental cavities	Y	N	P	Last tuberculin test	Y	N	P
Loss of taste	Y	N	P	Last chest x-ray	Y	N	P
Sores in & around mouth	Y	N	P	Other			
Other							
Breast				**Blood and lymphatic**			
Lumps	Y	N	P	Anemia	Y	N	P
Pain or tenderness	Y	N	P	Easy to bleed or bruising	Y	N	P
Nipple discharge	Y	N	P	Lymph node swelling	Y	N	P
Self-breast exams?	Y	N	P	Other			
Musculoskeletal				**Allergies, vaccination**			
Joint pain or stiffness	Y	N	P	Allergic to medication?	Y	N	P
Arthritis	Y	N	P	Side effects of vaccination?	Y	N	P
Broken bones	Y	N	P	Other allergies	Y	N	P
Muscle spasms or cramps	Y	N	P	Types of Allergy			
Weakness	Y	N	P				
Joint swelling	Y	N	P				
Backache	Y	N	P				

Gastrointestinal				**Cardiovascular**			
Trouble swallowing	Y	N	P	Heart disease	Y	N	P
Heartburn	Y	N	P	Angina	Y	N	P
Change in thirst	Y	N	P	High blood pressure	Y	N	P
Change in appetite	Y	N	P	Murmurs	Y	N	P
Nausea	Y	N	P	Rheumatic fever	Y	N	P
Vomiting	Y	N	P	Chest pain	Y	N	P
Vomiting blood	Y	N	P	Swelling in ankles	Y	N	P
Belching	Y	N	P	Palpitation/fluttering	Y	N	P
Passing gas	Y	N	P	Cyanosis	Y	N	P
Ulcer	Y	N	P	Other			
Indigestion	Y	N	P	**Peripheral vascular**			
Diarrhea	Y	N	P	Deep leg pain	Y	N	P
Abdominal pain	Y	N	P	Cold hands and feet	Y	N	P
Intestinal bleeding	Y	N	P	Varicose veins	Y	N	P
Rectal bleeding	Y	N	P	Thrombophlebitis	Y	N	P
Hemorrhoids	Y	N	P	Leg cramps	Y	N	P
Black tarry stool	Y	N	P	Extremity numbness	Y	N	P
Light grey stool	Y	N	P	Extremity swellings	Y	N	P
Liver disease	Y	N	P	Extremity ulcers	Y	N	P
Gallbladder disease	Y	N	P	Other			
Jaundice (Yellow skin)	Y	N	P	**Neurological**			
Hernias	Y	N	P	Dizziness	Y	N	P
Bowel movements (how often)		/ Day		Fainting	Y	N	P
Other				Seizures/Convulsions	Y	N	P
Endocrine				Paralysis	Y	N	P
Excessive thirst	Y	N	P	Muscle weakness	Y	N	P
Excessive urination	Y	N	P	Numbness or tingling	Y	N	P
Excessive sweating	Y	N	P	Loss of memory	Y	N	P
Excessive hair growth	Y	N	P	Involuntary movement	Y	N	P
Thyroid problems	Y	N	P	Loss of balance	Y	N	P
Diabetes	Y	N	P	Speech problems	Y	N	P
Other				Other			

Urinary				**Emotional**			
Pain on urination	Y	N	P	Depression	Y	N	P
Increased frequency	Y	N	P	Mania	Y	N	P
Frequency at night	Y	N	P	Mood swings	Y	N	P
Inability to hold urine	Y	N	P	Anxiety & nervousness	Y	N	P
Frequent urinary infection	Y	N	P	Phobia	Y	N	P
Kidney stones	Y	N	P	Insomnia	Y	N	P
Blood in urine	Y	N	P	Other			
Urgency	Y	N	P				
Hesitancy	Y	N	P				
Other							

Hobbies and Habits			
Do you enjoy your work?	Y	N	P
Do you exercise?	Y	N	P
Do you watch television	Y	N	P
If yes, how many hours do you watch?			
Do you take vacations?	Y	N	P
What are your hobbies?			

Male Only			
Do you usually get up to urinate during the night?	Y	N	P
If yes, how many times a night?			
Do you feel pain or burning with urination?	Y	N	P
Any blood in your urine?	Y	N	P
Do you feel burning discharge from penis?	Y	N	P
Has the force of urination decreased?	Y	N	P
Have you had any kidney, bladder, or prostate infections?	Y	N	P
Do you have any problem emptying your bladder completely?	Y	N	P
Any difficulty with erection or ejaculation?	Y	N	P
Any testicle pain or swellings	Y	N	P
Are you sexually active?	Y	N	
Date of last prostate and rectal exam?			

Female Only				
Age at onset of menstruation				
Date of last menstruation				
Period Cycle	☐Every ____days ☐ irregular (late or early) ☐ No period			
Heavy periods, irregularity, spotting, pain, or discharges?		Y	N	P
Are you sexually active?		Y	N	
If yes, are you trying to be pregnant?		Y	N	
If not trying to be pregnant, please identify the method of contraception				
Any discomfort or pain with intercourse?		Y	N	P
Are you pregnant?		Y	N	
Are you breastfeeding?		Y	N	P
Number of pregnancy				
Number of live birth				
Have you had a D&C, Hysterectomy, or Cesarean?		Y	N	P
Any urinary tract, bladder, or kidney infections?		Y	N	P
Any blood in your urine?		Y	N	P
Any problems with control of urination?		Y	N	P
Any hot flashes or sweating at night?		Y	N	P
Any menstrual pain, bloating, irritability, or other symptoms at or around the time of period?		Y	N	P
Experienced any recent breast tenderness, lumps, or nipple discharge?		Y	N	P
Date of last pap?				
