Global Wellness Health LLC

Comprehensive Intake Questionnaire

Please complete the following health history questionnaire to the best of your ability. You may need family members to help supply information. Your thoroughness and accuracy in answering all appropriate questions will help the provider evaluate the root cause of your health concerns and determine an effective treatment program.

Failure to list anything that you feel to be irrelevant could directly affect the outcome of your diagnosis and ultimately jeopardize a successful treatment outcome.

This program is HIPAA compliant. What this means to you: Any information that you enter into this program is made available only to you and your clinician, is password protected, and is in compliance with the Privacy Law under the Health Insurance Portability and Accountability Act.

Personal Information

Legal first name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Occupation

Hours per week

Referred by

Which pharmacy do you use? (Name, city and phone number)

Please list the lab where you would like for us to send your lab order.

Please list the providers you are currently seeing and why,

What is your height and weight?

Health History

When was the last time you felt well? Was there something that you feel may have triggered current symptoms?

Current Health Concerns

List your current health concerns in order of importance. List as many concerns or complaints as you can think of.

Health Concerns

Family History

Paternal Family Illnesses

Paternal Family Member	Illness

Maternal Family Illnesses

Maternal Family Member	Illness

Past Medical Diagnosis

Diagnosis	Current	Past	Date of Onset

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason

List any food or environmental allergies you experience

Food/Environmental Allergies	Reaction

Have you had any of the following surgeries?

- Tonsillectomy
- Gall bladder removal
- Hernia repair
- None of these
- Thyroidectomy
- Tubes in ears
- Removal of appendix
- Hysterectomy
- Appendectomy
- Bariatric surgery

Please check if you have had any of the following illnesses.

- Chicken Pox
- Measles
- Hepatitis
- COVID
- None of these
- Mono
- Mumps
- Tick born disease (Lyme disease)
- Guillain Barre Syndrome

Please check if you have had any of the following

- Cancer
- Stroke
- Untreated hypertension or blood pressure
- Liver injury or liver disease
- Blood clotting disorder
- Pancreatitis
- DVT (deep vein thrombosis)
- Heart attack
- Elevated PSA or abnormal prostate labs
- Vaginal bleeding between periods
- Blood clot
- None of these

Testing and Imaging

Have you had any of the following tests done?

- X-ray
- Mammogram
- Colonoscopy
- Upper GI (scope)
- Cat scan
- Bone density
- EKG
- Sigmoidoscopy
- Barium enema
- MRI

Ultrasound
Blood tests
Pap smear

Testing and Imaging continued

If you checked any of the boxes above, please explain why you had testing done and what the results were.

When was your last pap smear and what were the results?

When was your last mammogram and what were the results

Do you feel like you have a normal sex drive

Yes
No
Does not apply

Are you in menopause? Yes No

Please describe your periods/cycles if still having them.

Please describe sexual function/dysfunction.

Have you ever taken oral birth control? Yes No

Have you ever been on hormone replacement therapy? Yes No

When was the last time you took antibiotics?

Do you take medication for heartburn or acid reflux (Zantac, Prilosec, Tums, Pepcid, Nexium)?	Yes	No
Do you frequently take anti-inflammatory medication including ibuprofen, Advil, Naproxen or steroids?	Yes	No

Do you experience digestive difficulties? (i.e. bloating constipation, gas, abdominal pain)

How often do you have a bowel movement?

Do you strain to have a bowel movement?	Yes	No
Are your bowels loose?	Yes	No
Do you take laxatives?	Yes	No

Diet

How much water do you drink daily?

Do you consume coffee?	Yes	No
Do you consume tea?	Yes	No
Do you consume alcohol?	Yes	No

List any other drinks you consume

How many times a week do you eat meat?

How many vegetables do you eat per day?

How many fruits do you eat per day?

What are your favorite foods?

What foods do you avoid?

Do you experience any symptoms after meals?

Describe your relationship with food
Please be very specific

Do you exercise? If so, what do you do and how often?

Lifestyle

How many hours do you sleep a night?

Do you have trouble falling asleep? Staying asleep? You wake frequently during the night?

Do you wake feeling rested? Yes No

Do you experience afternoon fatigue? Yes No

What do you do to have fun?

Do you have any pets? Yes No

What level of stress are you currently experiencing?

List your main stressors

How many hours per day do you use a computer?

How many hours per day do you use a cell phone?

How many hours per day do you use watch TV?

Chemicals/Toxins

Where did you grow up? City or country? City Country

Have you ever lived or worked in a place that was damp or had mold? Yes No

What type of environment do you/ have you worked in?

How many cigarettes do you smoke per day?

If you quit, how long ago?

Do you or have you used recreational drugs? Yes No

Have you had any dental work done?
Do you have fillings (metal), root canals, crowns, etc?

Have you ever had shots/vaccinations? List all that apply (including flu shots)

Please provide any other information that may be relevant but hasn't been covered.

Please list the foods you have eat for breakfast, lunch and dinner in the past 24 hours including snacks and drinks.

Is there anything that will get in the way of following a treatment plan in order to achieve results?

What is your level of commitment to improving your health?

1 2 3 4 5 6 7 8 9 10

1 = Lowest, 10 = Highest