Dr. Lou Walters
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1924 W. Stevens Street, Suite 101, Bozeman, MT 59718
www.thesourcewellnesscenter.com

ADULT INTAKE

Name: ____ Date: ________________

Address: ____

City: ________________________________ State: _________ Zip: ____________________

Telephone (home): _______________ (work): ________________ (cell):_______________

Email address: ____

Age: _____ Date of Birth: _______________ Gender: Female / Male

Education: ____

Married:___ Separated:___ Divorced:___ Widowed:___ Single:___ Partnership:_____

Live with: Spouse:___ Partner:___ Parents:___ Children:___ Friends:___ Alone:___

Occupation: ____________________________ Hours per week: _______

Employer Name and Address: ____

____

How did you hear about this clinic? ____________________________________

If internet: Google:___ AANP Website:___ MANP Website:___ Other:____________

Has any other family member already been a patient at this clinic? ________________________

Emergency contact: ____________________________ Relationship: ____________________

Phone: ______________________ Address: ____________________________________

____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What *three* expectations do you have from *this* visit to our clinic?

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Patient: ______________________ *Date of Birth:* __________

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

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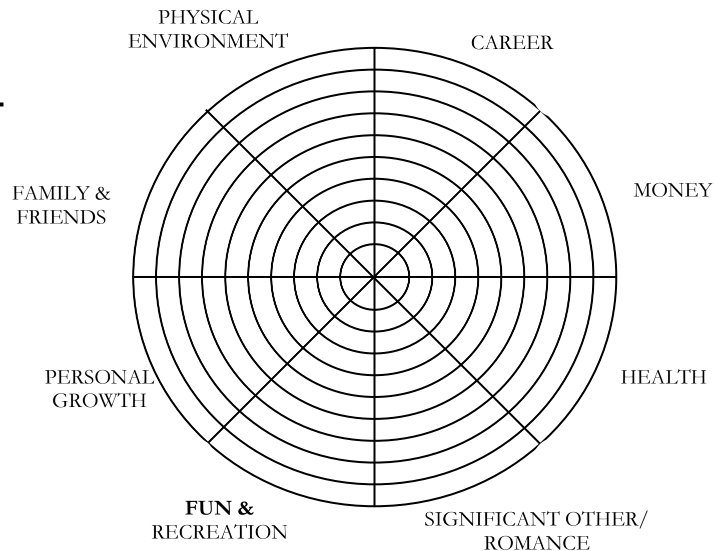
What do you love to do?

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



Are you currently receiving healthcare? Yes / No

If yes, where and from whom? ____

If no, when and where did you last receive medical or health care? ______________________

____

What was the reason? ____

What are your most important health problems? List as many as you can in order of importance.

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

7) ____

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Do you have any known contagious diseases at this time? Yes / No
If yes, what? ____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay fever	Hives	

Any other relevant family history? ____

What is your family heritage? ____

CHILDHOOD ILLNESSES

Weight at Birth:__________________

Please circle whether you had any of the following as a child:

Rheumatic fever	Diptheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

___________________________ year _______ _________________________ year _______
___________________________ year _______ _________________________ year _______
___________________________ year _______ _________________________ year _______

ALLERGIES

Are you hypersensitive or allergic to:
Any drugs? ____
Any foods? ____
Any environmentals or chemicals? ____

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CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping Pills	Thyroid Medication
Birth Control Pills	Hormone Replacement	Anti-Depressants	Blood Pressure Medication

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

1) ______________________________ 5) ______________________________
2) ______________________________ 6) ______________________________
3) ______________________________ 7) ______________________________
4) ______________________________ 8) ______________________________

GENERAL

Height: ______________ Weight: ______________ Weight one year ago: ___________
Maximum Weight: ___________________ When: ________________________________
When during the day is your energy the best? __________________ Worst? _________________
Main interests and hobbies: ____
Exercise: Y / N If so, what kind and how often: ________________________________
Watch TV: Y / N If so, how many hours? ______ Read: Y / N If so, how many hours? _______
Do you have a religious or spiritual practice? Y / N If so, what kind? _______________________

TYPICAL FOOD INTAKE

Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
To drink: ____

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FOR THE FOLLOWING, PLEASE CIRCLE:

Y =a condition you have now **N** =never had **P**=a significant problem in the past **S**=sometimes a problem

GENERAL				
Do you sleep well?	Y	N	P	S
Average 6-8 hours?	Y	N	P	S
Awake rested?	Y	N	P	S
Have a supportive relationship?	Y	N	P	S
Have a history of abuse?	Y	N	P	S
Experienced a major trauma?	Y	N	P	S
Use recreational drugs?	Y	N	P	S
Treated for drug dependence?	Y	N	P	S
Use alcoholic beverages?	Y	N	P	S
Use tobacco?	Y	N	P	S
If in the past, how many years?______________				
How many packs per day?_________________				
Do you enjoy your work?	Y	N	P	S
Take vacations?	Y	N	P	S
Spend time outside?	Y	N	P	S
Eat three meals a day?	Y	N	P	S
Do you go on diets often?	Y	N	P	S
Do you eat out often?	Y	N	P	S
Do you drink coffee?	Y	N	P	S
Drink black/green tea?	Y	N	P	S
Drink soda?	Y	N	P	S
Do you eat refined sugar?	Y	N	P	S
Do you add salt to your food?	Y	N	P	S
NEUROLOGIC				
Seizures?	Y	N	P	S
Muscle weakness?	Y	N	P	S
Loss of memory?	Y	N	P	S
Vertigo or dizziness?	Y	N	P	S
Paralysis?	Y	N	P	S
Numbness or tingling?	Y	N	P	S
Easily stressed?	Y	N	P	S
Loss of balance?	Y	N	P	S
ENDOCRINE				
Hypothyroid?	Y	N	P	S
Hypoglycemia?	Y	N	P	S
Excessive thirst?	Y	N	P	S
Fatigue?	Y	N	P	S
Heat or cold intolerance?	Y	N	P	S
Hyperthyroid?	Y	N	P	S
Diabetes?	Y	N	P	S
Excessive hunger?	Y	N	P	S
Seasonal depression?	Y	N	P	S
Difficulty exercising?	Y	N	P	S

IMMUNE				
Reactions to immunizations?	Y	N	P	S
Chronically swollen glands?	Y	N	P	S
Slow wound healing?	Y	N	P	S
Chronic fatigue syndrome?	Y	N	P	S
Chronic infections?	Y	N	P	S
Night sweats?	Y	N	P	S
EARS				
Impaired hearing?	Y	N	P	S
Ringing in ears?	Y	N	P	S
Dizziness?	Y	N	P	S
Ear aches?	Y	N	P	S
EYES				
Impaired vision?	Y	N	P	S
Cataracts?	Y	N	P	S
Glaucoma?	Y	N	P	S
Spots in vision?	Y	N	P	S
Color blindness?	Y	N	P	S
Tearing or dryness?	Y	N	P	S
Eye pain or strain?	Y	N	P	S
HEAD				
Headaches?	Y	N	P	S
Migraines?	Y	N	P	S
Head injury?	Y	N	P	S
Jaw or TMJ problems?	Y	N	P	S
NOSE AND SINUS				
Frequent colds?	Y	N	P	S
Stuffiness?	Y	N	P	S
Sinus problems?	Y	N	P	S
Nose bleeds?	Y	N	P	S
Hayfever?	Y	N	P	S
Loss of smell?	Y	N	P	S
NECK				
Lumps in neck?	Y	N	P	S
Goiter?	Y	N	P	S
Difficulty swallowing?	Y	N	P	S
Pain or stiffness in neck?	Y	N	P	S
MOUTH AND THROAT				
Frequent sore throat?	Y	N	P	S
Copious saliva?	Y	N	P	S
Sore tongue or lips?	Y	N	P	S

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MOUTH AND THROAT CONT.				
Hoarseness?	Y	N	P	S
Jaw clicks?	Y	N	P	S
Teeth grinding?	Y	N	P	S
Gum problems?	Y	N	P	S
Dental cavities?	Y	N	P	S
SKIN				
Rashes?	Y	N	P	S
Acne/boils?	Y	N	P	S
Change in skin color?	Y	N	P	S
Lumps or bumps on skin?	Y	N	P	S
Eczema or hives?	Y	N	P	S
Itching?	Y	N	P	S
Perpetual hair loss?	Y	N	P	S
RESPIRATORY				
Cough?	Y	N	P	S
Sputum?	Y	N	P	S
Asthma?	Y	N	P	S
Wheezing?	Y	N	P	S
Bronchitis?	Y	N	P	S
Coughing up blood?	Y	N	P	S
Shortness of breath?	Y	N	P	S
Shortness of breath lying down?	Y	N	P	S
Pain in breathing?	Y	N	P	S
Emphysema?	Y	N	P	S
Tuberculosis?	Y	N	P	S
GASTROINTESTINAL				
Trouble swallowing?	Y	N	P	S
Change in thirst?	Y	N	P	S
Change in appetite?	Y	N	P	S
Nausea/vomiting?	Y	N	P	S
Ulcer?	Y	N	P	S
Jaundice?	Y	N	P	S
Gall bladder disease?	Y	N	P	S
Liver disease?	Y	N	P	S
Hemorrhoids?	Y	N	P	S
Pancreatitis?	Y	N	P	S
Heartburn?	Y	N	P	S
Abdominal pain or cramps?	Y	N	P	S
Belching or passing gas?	Y	N	P	S
Constipation?	Y	N	P	S
Bowel movements: how often?	Y	N	P	S
Is this a change?____________________	Y	N	P	S

GASTROINTESTINAL CONT.				
Black stools?	Y	N	P	S
Blood in stools?	Y	N	P	S
MENTAL/EMOTIONAL				
Treated for emotional problem?	Y	N	P	S
Depression?	Y	N	P	S
Anxiety or nervousness?	Y	N	P	S
Poor concentration?	Y	N	P	S
Do you have mood swings?	Y	N	P	S
Considered suicide?	Y	N	P	S
Attempted suicide?	Y	N	P	S
Tension?	Y	N	P	S
Memory problems?	Y	N	P	S
URINARY				
Increased frequency of urination?	Y	N	P	S
Inability to hold urine?	Y	N	P	S
Pain in urination?	Y	N	P	S
Frequency at night?	Y	N	P	S
Frequent UTI's?	Y	N	P	S
Kidney stones?	Y	N	P	S
MUSCULOSKELETAL				
Joint pain or stiffness?	Y	N	P	S
Arthritis?	Y	N	P	S
Broken bones?	Y	N	P	S
Weakness?	Y	N	P	S
Muscle spasms or cramps?	Y	N	P	S
Sciatica?	Y	N	P	S
BLOOD				
Anemia?	Y	N	P	S
Easy bleeding or bruising?	Y	N	P	S
Cold hands/feet?	Y	N	P	S
Deep leg pain?	Y	N	P	S
Thrombophlebitis?	Y	N	P	S
Varicose veins?	Y	N	P	S
FEMALE REPRODUCTIVE				
Age of first menses:________				
Age of last menses (if menopausal):___				
Length of cycle:____________days				
Duration of menses:________days				
Are your cycles regular?	Y	N	P	S
Painful menses?	Y	N	P	S
Heavy or excessive flow?	Y	N	P	S
PMS?	Y	N	P	S

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FEMALE REPRODUCTIVE CONT.

PMS Symptoms:________________				
Bleeding between cycles?	Y	N	P	S
Clotting?	Y	N	P	S
Endometriosis?	Y	N	P	S
Ovarian cysts?	Y	N	P	S
Vaginal odor?	Y	N	P	S
Vaginal discharge?	Y	N	P	S
Date of last pap smear:___________				
Abnormal PAP?	Y	N	P	S
Cervical dysplasia?	Y	N	P	S
Are you sexually active?	Y	N	P	S
Sexual orientation:______________				
Birth control? Type:_____________				
Pain during intercourse?	Y	N	P	S
Gonorrhea?	Y	N	P	S
Herpes?	Y	N	P	S
Chlamydia?	Y	N	P	S
Genital warts?	Y	N	P	S
Syphilis?	Y	N	P	S
Difficulty conceiving?	Y	N	P	S
Number of pregnancies:__________				
Number of live births:____________				
Number of miscarriages:__________				
Number of abortions:____________				
Do you do self breast exams?	Y	N	P	S
Breast pain/tenderness?	Y	N	P	S
Breast lumps?	Y	N	P	S
Nipple discharge?	Y	N	P	S
Menopausal symptoms?	Y	N	P	S

MALE REPRODUCTIVE

Are you sexually active?	Y	N	P	S
Sexual orientation:_____________				
Birth control? Type:_____________				
Discharge or sores?	Y	N	P	S
Chlamydia?	Y	N	P	S
Genital warts?	Y	N	P	S
Herpes?	Y	N	P	S
Syphilis?	Y	N	P	S
Hernias?	Y	N	P	S
Testicular masses?	Y	N	P	S
Testicular pain?	Y	N	P	S
Prostate disease?	Y	N	P	S
Impotence?	Y	N	P	S
Premature ejaculation?	Y	N	P	S