

**LEHIGH VALLEY WELLNESS CENTER**

101 Coventry Drive  
Phillipsburg, NJ 08865

**CLIENT INTAKE FORM**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Full Name:		Gender: <input type="radio"/> Male <input type="radio"/> Female
Address:		DOB:
State:		City:
Zip Code:		Email:
Phone:		Secondary Phone:

Marital Status: <input type="radio"/> Single <input type="radio"/> Partnered <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed
---

Previous or Referring Practitioner:	Date of last physical exam:
-------------------------------------	-----------------------------

**PERSONAL HEALTH HISTORY**

Childhood Illness:	<input type="radio"/> Measles <input type="radio"/> Mumps <input type="radio"/> Rubella <input type="radio"/> Chickenpox <input type="radio"/> Polio <input type="radio"/> Rheumatic <input type="radio"/> Fever <input type="radio"/> Other: _____
--------------------	--

Immunizations and Dates:	Tetanus:	Chicken Pox:
	Pneumonia:	Influenza:
	Hepatitis:	MMR:

List any medical problems that other providers have diagnosed:  _____  _____  _____  _____
--

Surgeries:		
Year	Reason	Hospital/Facility

Other Hospitalizations:		
Year	Reason	Hospital/Facility

Have you ever had a blood transfusion?	<input type="radio"/> Yes <input type="radio"/> No
--	--

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
Drug Name	Strength	Frequency Taken

Allergies to medications	
Drug Name	Reaction

**HEALTH HABITS AND PERSONAL SAFETY**

Exercise:	<input type="radio"/> Sedentary (No exercise)	<input type="radio"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	<input type="radio"/> Occasional vigorous exercise (i.e. work Or recreation)	<input type="radio"/> Regular vigorous exercise

Diet:	Are you dieting?	<input type="radio"/> Yes <input type="radio"/> No
	If yes, are you on a practitioner prescribed medical diet?	<input type="radio"/> Yes <input type="radio"/> No

	Number of meals you eat in an average day?	_____
	Rank salt intake	<input type="radio"/> High <input type="radio"/> Medium <input type="radio"/> Low
	Rank fat intake	<input type="radio"/> High <input type="radio"/> Medium <input type="radio"/> Low
	Do you have cravings for sugar and/or processed, starchy foods?	<input type="radio"/> Yes <input type="radio"/> No

Caffeine:	<input type="radio"/> None <input type="radio"/> Coffee <input type="radio"/> Tea <input type="radio"/> Cola
	Number of cups/cans per day? _____

Foods:	Beef/Pork/Lamb	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Fish	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Chicken	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Fresh Vegetables	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Fresh Fruit	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Fast Foods	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Cookies, Pastries, Cakes	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Canned Foods	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Soda, including Diet	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Sugar or Sugary Foods	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Whole Grains	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Dairy Products	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Raw seeds and/or Nuts	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Olive Oil	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Fried Foods	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Packaged Snack Foods	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Beans, Lentils, or Peas	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Raw Foods	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Eggs	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
	Cold Breakfast Foods (Cereals)	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never
Hot Breakfast Foods	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never	
Prepackaged Foods	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never	
Organic Foods	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never	
White Rice	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never	
Whole Grain/ Long Grain Rice	<input type="radio"/> Every day <input type="radio"/> Often <input type="radio"/> Sometimes <input type="radio"/> Never	

Water:	Do you drink water?	<input type="radio"/> Yes <input type="radio"/> No
	How much water do you drink (number of glasses per day)?	_____
	What type of water do you drink: <input type="radio"/> Bottled <input type="radio"/> Tap <input type="radio"/> Filtered <input type="radio"/> Reverse Osmosis <input type="radio"/> Flavored	
	Do you drink water only when you are thirsty?	<input type="radio"/> Yes <input type="radio"/> No

Alcohol:	Do you drink alcohol?	<input type="radio"/> Yes <input type="radio"/> No
	If yes, what kind?	_____
	How many drinks per week?	_____
	Are you concerned about the amount you drink?	<input type="radio"/> Yes <input type="radio"/> No
	Have you considered stopping?	<input type="radio"/> Yes <input type="radio"/> No
	Have you ever experienced blackouts?	<input type="radio"/> Yes <input type="radio"/> No
	Are you prone to "binge" drinking?	<input type="radio"/> Yes <input type="radio"/> No

	Do you drive after drinking?	<input type="radio"/> Yes <input type="radio"/> No
--	------------------------------	--

Tobacco:	Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No
	_____ Cigarettes – pks./day	_____ chew - #/day
	_____ Pipe - #/day	_____ Cigars - #/day
	_____ # of years	_____ or year quit

Drugs:	Do you currently use recreational or street drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Have you ever given yourself street drugs with a needle?	<input type="radio"/> Yes <input type="radio"/> No

Sex:	Are you sexually active?	<input type="radio"/> Yes <input type="radio"/> No
	Are you using contraceptives or barrier method for STDs?	<input type="radio"/> Yes <input type="radio"/> No
	Any discomfort with intercourse?	<input type="radio"/> Yes <input type="radio"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="radio"/> Yes <input type="radio"/> No

Personal Safety:	Do you live alone?	<input type="radio"/> Yes <input type="radio"/> No
	Do you have frequent falls?	<input type="radio"/> Yes <input type="radio"/> No
	Are you afraid for your personal safety?	<input type="radio"/> Yes <input type="radio"/> No
	Have you had any major exposure to toxic chemicals?	<input type="radio"/> Yes <input type="radio"/> No
	If yes, please explain: _____ _____	
	Have you been exposed to radiation, including x-rays? Dental X-rays?	<input type="radio"/> Yes <input type="radio"/> No
	Have you been exposed to radon, asbestos, or lead?	<input type="radio"/> Yes <input type="radio"/> No
	Have you ever had any physical attacks or assaults either by a family member and/or stranger?	<input type="radio"/> Yes <input type="radio"/> No

### FAMILY HEALTH HISTORY

AGE	SIGNIFICANT HEALTH PROBLEMS	
Father	_____	
Mother	_____	

<b>MENTAL HEALTH</b>	
Is stress a major problem for you?	<input type="radio"/> Yes <input type="radio"/> No
Do you feel depressed?	<input type="radio"/> Yes <input type="radio"/> No
Do you panic when stressed?	<input type="radio"/> Yes <input type="radio"/> No
Do you have problems with eating or your appetite?	<input type="radio"/> Yes <input type="radio"/> No
Do you cry frequently?	<input type="radio"/> Yes <input type="radio"/> No
Have you ever attempted suicide?	<input type="radio"/> Yes <input type="radio"/> No
Have you ever seriously thought about hurting yourself?	<input type="radio"/> Yes <input type="radio"/> No
Do you have trouble sleeping?	<input type="radio"/> Yes <input type="radio"/> No
Have you ever been to a counselor?	<input type="radio"/> Yes <input type="radio"/> No
Is your job or occupation fulfilling for you?	<input type="radio"/> Yes <input type="radio"/> No
Is your job stressful?	<input type="radio"/> Yes <input type="radio"/> No
Do you feel connected to the world of nature?	<input type="radio"/> Yes <input type="radio"/> No
Do you have pets?	<input type="radio"/> Yes <input type="radio"/> No
Do you have a sense of spirituality, regular spiritual practice (if that's important to you)?	<input type="radio"/> Yes <input type="radio"/> No
Do you feel that you have an underlying purpose in your life?	<input type="radio"/> Yes <input type="radio"/> No
Do you feel you have enough quality time alone?	<input type="radio"/> Yes <input type="radio"/> No
Do you have creative outlets to vent your stress and/or negative energy?	<input type="radio"/> Yes <input type="radio"/> No
Any other issues you would like to address?	
_____	
_____	
_____	

<b>WOMEN ONLY</b>	
Age at onset of menstruation: _____	
Date of last menstruation: _____	
Period: every _____ days	
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="radio"/> Yes <input type="radio"/> No
Number of pregnancies: _____ Number of live births: _____	
Are you pregnant or breastfeeding?	<input type="radio"/> Yes <input type="radio"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="radio"/> Yes <input type="radio"/> No
Any urinary tract, bladder, or kidney infections with the last year?	<input type="radio"/> Yes <input type="radio"/> No
Any blood in your urine?	<input type="radio"/> Yes <input type="radio"/> No
Any problems with control of urination?	<input type="radio"/> Yes <input type="radio"/> No
Any hot flashes or sweating at night?	<input type="radio"/> Yes <input type="radio"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="radio"/> Yes <input type="radio"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="radio"/> Yes <input type="radio"/> No
Do you have trouble sleeping?	<input type="radio"/> Yes <input type="radio"/> No
Are you pregnant or are you trying for pregnancy?	<input type="radio"/> Yes <input type="radio"/> No

<b>MEN ONLY</b>	
Do you usually get up to urinate during the night?	<input type="radio"/> Yes <input type="radio"/> No
If yes, number of times _____	
Do you feel pain or burning with urination?	<input type="radio"/> Yes <input type="radio"/> No
Any blood in your urine?	<input type="radio"/> Yes <input type="radio"/> No
Do you feel burning discharge from penis?	<input type="radio"/> Yes <input type="radio"/> No
Has the force of your urination decreased?	<input type="radio"/> Yes <input type="radio"/> No
Have you had any kidney, bladder, or prostate infections with the last 12 months?	<input type="radio"/> Yes <input type="radio"/> No
Do you have any problems emptying your bladder completely?	<input type="radio"/> Yes <input type="radio"/> No
Any difficulty with erection or ejaculation?	<input type="radio"/> Yes <input type="radio"/> No
Any testicle pain or swelling?	<input type="radio"/> Yes <input type="radio"/> No
Date of last prostate and rectal exam: _____	

**REVIEW OF SYSTEMS (Check off all that apply)**

<input type="checkbox"/> Recent weight changes	<input type="checkbox"/> Changes in nail/hair	<input type="checkbox"/> Urination problems
<input type="checkbox"/> Weakness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Fever	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Glaucoma or Cataracts	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Cough	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Other Pain: _____
<input type="checkbox"/> Sputum Production	<input type="checkbox"/> Earaches	<input type="checkbox"/> Numbness in hands/feet
<input type="checkbox"/> Blood in Sputum	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma, Bronchitis	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tremors
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> TB	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Depression
<input type="checkbox"/> Rashes	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Nausea or Vomiting
<input type="checkbox"/> Color Change (skin)	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation
<input type="checkbox"/> Excessive Dryness (skin)	<input type="checkbox"/> Excessive Perspiration	

Describe anything not listed above that is bothersome for you:

---



---



---

**TREATMENT QUESTIONNAIRE (Answer ALL That Apply)**

Decreased Concentration	<input type="radio"/> Yes <input type="radio"/> No	Decreased sociability	<input type="radio"/> Yes <input type="radio"/> No
Increased mood swings	<input type="radio"/> Yes <input type="radio"/> No	Decreased short term memory	<input type="radio"/> Yes <input type="radio"/> No
Increased stress levels	<input type="radio"/> Yes <input type="radio"/> No	Decreased long term memory	<input type="radio"/> Yes <input type="radio"/> No
Decreased personal drive	<input type="radio"/> Yes <input type="radio"/> No	Decreased sense of well being	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Feeling less confident	<input type="radio"/> Yes <input type="radio"/> No
Difficulties sleeping	<input type="radio"/> Yes <input type="radio"/> No	Decreased sex drive	<input type="radio"/> Yes <input type="radio"/> No
Decreased energy	<input type="radio"/> Yes <input type="radio"/> No	Decreased endurance	<input type="radio"/> Yes <input type="radio"/> No
Decreased exercise	<input type="radio"/> Yes <input type="radio"/> No	Healing from exercise is long	<input type="radio"/> Yes <input type="radio"/> No

Decreased muscle strength	<input type="radio"/> Yes <input type="radio"/> No	Decreased testicle size	<input type="radio"/> Yes <input type="radio"/> No
Decreased skin elasticity	<input type="radio"/> Yes <input type="radio"/> No	Decreased skin tone	<input type="radio"/> Yes <input type="radio"/> No
Decreased libido	<input type="radio"/> Yes <input type="radio"/> No	Increased fat deposits	<input type="radio"/> Yes <input type="radio"/> No
Increased wrinkles	<input type="radio"/> Yes <input type="radio"/> No	Increased muscle deterioration	<input type="radio"/> Yes <input type="radio"/> No
Increased fatigue	<input type="radio"/> Yes <input type="radio"/> No	Gynecomastia (male breast)	<input type="radio"/> Yes <input type="radio"/> No
Nipple sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Hot Flashes	<input type="radio"/> Yes <input type="radio"/> No
Heavy menstrual cycle	<input type="radio"/> Yes <input type="radio"/> No	Painful menstrual cycle	<input type="radio"/> Yes <input type="radio"/> No
Temperature intolerance	<input type="radio"/> Yes <input type="radio"/> No	Oral birth control or estrogen	<input type="radio"/> Yes <input type="radio"/> No
Thinning or loss of hair	<input type="radio"/> Yes <input type="radio"/> No	Thinning pubic hair	<input type="radio"/> Yes <input type="radio"/> No
Sagging or loose skin	<input type="radio"/> Yes <input type="radio"/> No	Thin/dry skin	<input type="radio"/> Yes <input type="radio"/> No
Stiff joints in morning	<input type="radio"/> Yes <input type="radio"/> No	Decreased bone mass	<input type="radio"/> Yes <input type="radio"/> No
Progressive osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Increased joint pain	<input type="radio"/> Yes <input type="radio"/> No
Increased back pain	<input type="radio"/> Yes <input type="radio"/> No	Gastrointestinal bleeding	<input type="radio"/> Yes <input type="radio"/> No
Muscle aches and pains	<input type="radio"/> Yes <input type="radio"/> No	Joint pain during exercise	<input type="radio"/> Yes <input type="radio"/> No

### HEALTH INFORMATION AUTHORIZATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (mm/dd/yyyy)

As required by the HIPAA Privacy Regulations, this practice may not use or disclose your protected health information without your authorization.

#### Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize the staff of **Lehigh Valley Wellness Center** to use and/or disclose certain protected health information (PHI) about me to individual/facilities, health care insurance companies involved with my health care.

This authorization permits **Lehigh Valley Wellness Center** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.)

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI except by the health care insurance companies for the purposes of payment of services rendered to you for your care.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy office at: **Lehigh Valley Wellness Center at 101 Coventry Drive, Phillipsburg, NJ 08865.**

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian Relationship to Patient

\_\_\_\_\_  
Print Patient's Name Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian, if applicable

**Consent for Treatment:**

I hereby authorize **Lehigh Valley** or any its employees to use the information in this questionnaire to evaluate my present health states and provide recommendations for improving my health and wellness.

I am aware that the recommendations may consist of dietary modifications, the addition of vitamin/mineral and herbal supplements, exercise routines and/or other alternative treatments such as massage or chiropractic care.

These recommendations are based on the evaluation of the practitioner which are formulated by the findings of an interview, a physical assessment and review of the information provided in this questionnaire.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_