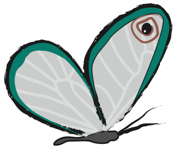

Awakening Wellness, LLC

Date of first visit: ___________________

Name: ____

Address: ____

Home Number: ___________________ Cell Number:____________________________

E-mail address: ____

DOB: _________________
Age: ______

Number of Children: __________ Age of children: ______________

Occupation: __________________

General Health History:

List in order of **Most** important to **Least** important areas of pain or dysfunction you feel are present in your body:

Date of dysfunction

1.

2.

3.

Have you seen a general practitioner or specialist for any of these problems? Yes / No
____

Was there any treatment or diagnosis given? Yes / No

____

Has the condition changed with treatment?

General Health – please answer or circle appropriate response

Have you recently had any rapid weight gain or loss?
General energy level (scale of 1-10, 10 being optimal)
Average hours of sleep per night:
Do you wake up feeling refreshed? Yes / No
Do you have difficulty falling asleep? Yes/ No
Do you have insomnia? Yes/ No
Do you have depression or anxiety? Yes/ No
Do you feel extreme stress or pressure (general life, work) from day to day? Yes/ No

Do you wake up at night to go to the bathroom? Yes/ No
Can you fall back asleep easily? Yes/ No

Do you smoke presently? Yes/ No
How long have you smoked?
Have you ever smoked? Yes/ No

Do you drink alcohol? Yes / No How often?
Do you drink coffee? Yes/ No How much per day?
Do you drink soda? Yes/ No How much per day?
How much water do you drink per day?

Do you exercise regularly? Yes/ No
Types of exercise:
Do you take any vitamin or supplemental products?

Have you been diagnosed with cancer? Yes/ No Type:
Have you ever had any surgeries? Yes/ No
If **Yes** circle type below:
Bone, Tumor, Dental Cosmetic, Muscular
Cartilage, Tendon, Organ, Eye, Ear
Implants, Transplants, Pacemakers, Stents, Shunts, Joint replacements?

Have you ever been hospitalized? Yes/ No How long?

Car Accidents? Yes/ No How many?
Broken Bones? Yes/ No Which bones?
Sprains or Dislocations? Yes/ No Where?
Any Large Scars? Yes/ No Where?
Other injuries? ____

Please list all supplements and medications. Include the conditions it is for.

____
____
____

Musculoskeletal System: Check any areas that currently apply – mark a P for past issue

_______Low back pain
_______Mid-back pain
_______Neck pain
_______Arm pain
_______Leg pain
_______Joint pain
_______Cartilage tears
_______Constant joint stiffness/ache
_______Difficulty walking
_______Broken bones
_______Shoulder pain
_______Torn muscles
_______Muscle strains
_______Ligament sprains
_______Arthritis

Nervous system

_______Numbness/tingling
_______Loss of balance
_______Dizziness or Vertigo
_______Fainting
_______Frequent Headaches or Migraines
_______Loss of coordination
_______Frequent Muscle Twitching, tics or spasms
_______Seizures
_______Hearing problems

Mouth, Throat, Neck

_______Dental crowns, bridges, mouth work
_______Trouble swallowing
_______Grinding of teeth, TMJ, Clicking Jaw
_______ Braces (current or history)

Respiratory System

_______Asthma
_______Pain on breathing
_______Chronic/frequent coughing
_______Frequent shortness of breath
_______Regular Colds or Infections

Cardiovascular System and Peripheral Vascular System

_______High/low blood pressure
_______Varicose veins
_______ Heart murmurs
_______ Irregular heart beat
_______Heart palpitations
_______ Anemia

Gastrointestinal System

_______Frequent Constipation
_______Frequent cramps

_______Frequent diarrhea
_______Abdominal pain
_______Colitis, Crohn’s Disease, or Ulcers
_______Frequent indigestion or gas
_______Frequent heartburn

Reproductive System

_______Menopause or peri-menopausal symptoms
_______Frequent cramping_
______ Currently pregnant (list week if checked)
_______Fibroids, cysts, or endometriosis
_______C-section
______Irregular cycle