#LIVELONGLIVEWELL
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WELLNESS
INTAKE PAPERWORK

CONTACT

LVWellness & Aesthetics

7030 FM 1488, Suite 220
Magnolia, TX
77354

Phone: 346-703-2075
Email: info@lvwell.com
Website: lvwell.com

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HEALTH & HISTORY QUESTIONNAIRE

GENERAL INFORMATION

Name: ______________________

Preferred Name: ______________ Date: ______________

Address: ______________________

City: ______________ State: __________ Zip Code: __________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Email: ______________________

Age: __________ Date of Birth: ______________ Gender: o Female o Male

Genetic Background: o Caucasian o African o Native American o Hispanic o Asian
o Other ______________________

Marital Status: o Married o Separated o Divorced o Widowed o Single o Partnership

Number of Children: __________ Ages: ______________

Has any other family member already been a client at the facility? ______________

Occupation: ______________________

Emergency Contact: ______________________

Relationship: ______________ Phone Number: ______________

Primary Physicians Name: ______________________

Phone Number: ______________ Fax: ______________

How did you hear about us?

o Friend/Family: ______________

o Staff Member ______________

o Online: ______________

o Advertising/Print: ______________

o Woodforest Neighbor: ______________

o Other: ______________

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HEALTH & HISTORY QUESTIONNAIRE

MEDICAL HISTORY

GASTROINTESTINAL
- ○ Irritable Bowel Syndrome ____________
- ○ Inflammatory Bowel Disease ____________
- ○ Crohn's ____________
- ○ Ulcerative Colitis ____________
- ○ Gastritis or Peptic Ulcer Disease ____________
- ○ GERD (reflux) ____________
- ○ Celiac Disease ____________
- ○ Other ____________

CARDIOVASCULAR
- ○ Heart Attack ____________
- ○ Other Heart Disease ____________
- ○ Stroke ____________
- ○ Elevated Cholesterol ____________
- ○ Arrhythmia (irregular heart rate) ____________
- ○ Hypertension ____________
- ○ Rheumatic Fever ____________
- ○ Mitral Valve Prolapse ____________
- ○ Other ____________

METABOLIC/ENDOCRINE
- ○ Type 1 Diabetes ____________
- ○ Type 2 Diabetes ____________
- ○ Low Blood Sugar ____________
- ○ Insulin Resistance/Pre-Diabetes ____________
- ○ Hypothyroidism ____________
- ○ Hyperthyroidism ____________
- ○ Endocrine Problems ____________
- ○ Infertility ____________
- ○ Weight Gain ____________
- ○ Weight Loss ____________
- ○ Frequent Weight Fluctuations ____________
- ○ Bulimia ____________
- ○ Anorexia ____________
- ○ Binge Eating Disorder ____________
- ○ Night Eating Syndrome ____________
- ○ Eating Disorder (non-specific) ____________
- ○ Other ____________

CANCER
- ○ Lung Cancer ____________
- ○ Breast Cancer ____________
- ○ Colon Cancer ____________
- ○ Cardiac Stress Test ____________
- ○ EBT Heart Scan ____________
- ○ Ovarian Cancer ____________
- ○ Skin Cancer ____________
- ○ Prostate Cancer ____________
- ○ Other ____________

GENITAL AND URINARY SYSTEMS
- ○ Kidney Stones ____________
- ○ Gout ____________
- ○ Frequent UTI's ____________
- ○ BPH (Enlarged Prostate) ____________
- ○ Frequent Yeast Infections ____________
- ○ Erectile Dysfunction ____________
- ○ Sexual Dysfunction ____________
- ○ Other ____________

MUSCULOSKELETAL/PAIN
- ○ Osteoarthritis ____________
- ○ Fibromyalgia ____________
- ○ EKG ____________
- ○ Chronic Pain ____________
- ○ Other ____________

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HEALTH & HISTORY QUESTIONNAIRE

MEDICAL HISTORY (PAGE 2)

INFLAMMATORY/AUTOIMMUNE

- ○ Chronic Fatigue Syndrome ____________
- ○ Autoimmune Disease ____________
- ○ Lupus SLE ____________
- ○ Immune Deficiency Disease ____________
- ○ Herpes-Genital ____________
- ○ Severe Infectious Disease ____________
- ○ Lyme Disease ____________
- ○ Poor Immune Function ____________
- ○ Food Allergies ____________
- ○ Environmental Allergies ____________
- ○ Multiple Chemical Sensitivities ____________
- ○ Latex Allergy ____________
- ○ Other ____________

RESPIRATORY DISEASES

- ○ Asthma ____________
- ○ Chronic Sinusitis ____________
- ○ Bronchitis ____________
- ○ Emphysema ____________
- ○ Pneumonia ____________
- ○ Tuberculosis ____________
- ○ Sleep Apnea ____________
- ○ Other ____________

SKIN DISEASES

- ○ Eczema ____________
- ○ Psoriasis ____________
- ○ Acne ____________
- ○ Melanoma ____________
- ○ Skin Cancer ____________
- ○ Other ____________

NEUROLOGIC/MOOD

- ○ Depression ____________
- ○ Anxiety ____________
- ○ Bipolar Disorder ____________
- ○ Schizophrenia ____________
- ○ Headaches ____________
- ○ Migraines ____________
- ○ ADD/ADHD ____________
- ○ Autism ____________
- ○ Mild Cognitive Impairment ____________
- ○ Memory Problems ____________
- ○ Parkinson's Disease ____________
- ○ Multiple Sclerosis ____________
- ○ ALS ____________
- ○ Seizures ____________
- ○ Other Neurological Problems ____________

PREVENTIVE TESTS AND DATE OF LAST TEST

- ○ Full Physical Exam ____________
- ○ Bone Density ____________
- ○ Colonoscopy ____________
- ○ Cardiac Stress Test ____________
- ○ EBT Heart Scan ____________
- ○ EKG ____________
- ○ Hemoccult Test (Test Stool for Blood) ____________
- ○ MRI ____________
- ○ CT Scan ____________
- ○ Upper Endoscopy ____________
- ○ Upper GI Series ____________
- ○ Ultrasound ____________

INJURIES

○ Back Injury ○ Head Injury ○ Neck Injury ○ Broken Bones

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HEALTH & HISTORY QUESTIONNAIRE

ALLERGIES

Medication/Supplement/Food: ____________________

____

Reaction ____________________

____

NUTRITION HISTORY

Have you ever had a nutrition consultation? ○ Yes ○ No

Have you made any changes in your eating habits because of your health? ○ Yes ○ No

Describe: ____________________

Do you currently follow a special diet or nutritional program? ○ Yes ○ No

Check all that apply: ○ Low Fat ○ Low Carbohydrate ○ High Protein ○ Low Sodium
○ Diabetic ○ No Dairy ○ No Wheat ○ Gluten Restricted ○ Vegetarian ○ Vegan
○ Specific Program for Weight Loss and Type of Program: ____________________
○ Other:

Pregnant: ○ Yes ○ No

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit? ____________________

____

When was the last time you felt well? ____________________

____

Did something trigger your change in health? ____________________

____

What makes you feel worse? ____________________

____

What makes you feel better? ____________________

____

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HEALTH & HISTORY QUESTIONNAIRE

SMOKING

Currently Smoking? ○ Yes ○ No
How many years: ________ Packs per day: ________ Attempts to quit: ________
Previous Smoking? ○ Yes ○ No How many years: ________ Packs per day: ________
Second hand smoke exposure? ________

ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces of wine, 12 ounces beer, 1.5 ounces spirits
○ None ○ 1-3 ○ 4-6 ○ 7-10 ○ >10
Previous Alcohol Intake? ○ Mild ○ Moderate ○ High

OTHER SUBSTANCES

Coffee Intake: ○ Yes ○ No
Coffee Cups/Day: ○ 1 ○ 2-4 ○ >4 Tea Cups/Day: ○ 1 ○ 2-4 ○ >4
Caffeinated Soda or Diet Soda: ○ Yes ○ No
Are you currently using any recreational drugs? ○ Yes ○ No If so, which one(s)? ________
Have you previously used a recreational drug? ○ Yes ○ No If so, when? ________

SLEEP/REST

Average number of hours you sleep per night? ________
Do you have trouble falling asleep? ○ Yes ○ No
Do you feel rested upon awakening? ○ Yes ○ No
Do you have a problem with insomnia? ○ Yes ○ No
Do you snore? ○ Yes ○ No Do you use sleep aids? ○ Yes ○ No

EXERCISE

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength Training			
Yoga, Pilates, Barre			
Sports or Leisure Activities (golf, tennis, roller blading, etc.)			

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HEALTH & HISTORY QUESTIONNAIRE

LIST OF SURGERIES

____

____

____

CURRENT MEDICATION / MEDICATION HISTORY

____

____

____

____

FAMILY HISTORY

Mother ______________________________________

Father ______________________________________

Siblings _____________________________________

Grandparents _________________________________

Other _______________________________________

____

PHARMACY INFORMATION

Pharmacy Name ________________________________

Phone Number _________________________________

Address _____________________________________

City ______________ State __________ Zip __________

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HEALTH & HISTORY QUESTIONNAIRE

GYNECOLOGIC HISTORY

OBSTETRIC HISTORY (Check box if yes and provide number)

○ Pregnancies ____________________
○ Miscarriages ____________________
○ Post Postpartum Depression __________
○ Breast Feeding? For how long? ______
○ Living Children? __________________
○ Cesarean ____________________
○ Abortion ____________________
○ Toxemia ____________________
○ Vaginal deliveries ____________________
○ Gestational Diabetes ________________

MENSTRUAL HISTORY

Age at First Period:______ Menses Frequency: ______ Length: ______ Pain? ○ Yes ○ No
Clotting? ○ Yes ○ No Do you have Irregular Periods? ○ Yes ○ No
Last Menstrual Period: ________________
Use of Contraception such as: ○ Birth Control Pill ○ Patch ○ Nuva Ring ○ IUD
○ Vasectomy
For how long?______

WOMEN'S DISORDERS/HORMONAL IMBALANCES

○ Fibrocystic Breasts
○ Endometriosis
○ Fibroids
○ PMS
○ Infertility
○ Painful Periods
○ Heavy Periods

Last Mammogram: _________ Breast Biopsy/Date: _________
Last PAP Test:_________ ○ Normal ○ Abnormal
Last Bone Density: _________ Results: ○ High ○ Low ○ Normal Range
Are you in Menopause? ○ Yes ○ No
Age at Menopause? _________

○ Hot Flashes ○ Mood Swings ○ Concentration/Memory Problems
○ Vaginal Dryness ○ Decreased Libido ○ Heavy Bleeding
○ Joint Pains ○ Headaches ○ Weight Gain ○ Loss of Control of Urine
○ Palpitations ○ Use of Hormone Replacement Therapy? How long? _________

MEN'S HISTORY

Have you had a PSA done? ○ Yes ○ No
PSA Level: ○ 0-2 ○ 2-4 ○ 4-10 ○ >10
○ Prostate Enlargement ○ Prostate Infection ○ Change in Libido ○ Impotence
○ Difficult Obtaining an Erection ○ Difficulty Maintaining an Erection
○ Nocturia (urination at night) How many times at night? _________
○ Urgency/Hesitancy/Change in Urinary Stream ○ Loss of Control of Urine

HEALTH & HISTORY QUESTIONNAIRE

SYMPTOM REVIEW

GENERAL
- ○ Cold Hands & Feet
- ○ Cold Intolerance
- ○ Low Bow Temperature
- ○ Low Blood Pressure
- ○ Daytime Sleepiness
- ○ Fatigue
- ○ Fever
- ○ Flushing
- ○ Heat Intolerance

HEAD, EYES & EARS
- ○ Conjunctivitis
- ○ Eye Pain
- ○ Hearing Loss
- ○ Hearing Problems
- ○ Headache
- ○ Migraine
- ○ Vision Problem (other than glasses)

MUSCULOSKELETAL
- ○ Back Muscle Spasm
- ○ Calf Cramps
- ○ Chest Tightness
- ○ Foot Cramps
- ○ Joint Pain
- ○ Joint Stiffness
- ○ Muscle Pain
- ○ Muscle Spasms
- ○ Muscle Stiffness

MOOD/NERVES
- ○ Depression
- ○ Seizures
- ○ Difficulty:
  - ○ Concentrating
  - ○ With Balance
  - ○ With Thinking
  - ○ With Judgment
  - ○ With Speech
  - ○ With Memory

EATING
- ○ Binge Eating
- ○ Bulimia
- ○ Can't Gain Weight
- ○ Can't Lose Weight
- ○ Can't Maintain Healthy WeightGERD (reflux)
- ○ Frequent Dieting
- ○ Poor Appetite

DIGESTION
- ○ Anal Spasms
- ○ Bloating of:
  - ○ Lower Abdomen
  - ○ Whole Abdomen
  - ○ Bloating After Meals
- ○ Blood in Stools
- ○ Diarrhea
- ○ Alternating Diarrhea and Constipation
- ○ Heartburn
- ○ Intolerance to:
  - ○ Lactose
  - ○ All Dairy Products
  - ○ Gluten (Wheat, Rye, Barley)
  - ○ Corn
  - ○ Eggs
  - ○ Fatty Foods
  - ○ Yeast

SKIN PROBLEMS
- ○ Acne
- ○ Athlete's Foot
- ○ Cellulite
- ○ Dark Circles Under Eyes
- ○ Eczema
- ○ Oily Skin
- ○ Dry Skin
- ○ Normal Skin
- ○ Pale Skin
- ○ Patchy Dullness
- ○ Rash
- ○ Hair Loss

HEALTH & HISTORY QUESTIONNAIRE

SYMPTOM REVIEW

LYMPH NODES
- ○ Enlarged/Neck
- ○ Tender/Neck
- ○ Other Enlarged/Tender
- ○ Lymph Nodes

NAILS
- ○ Fungus-Fingers
- ○ Fungus-Toes
- ○ Pitting

RESPIRATORY
- ○ Cough-Dry
- ○ Cough-Productive
- ○ Hoarseness
- ○ Sore Throat
- ○ Post Nasal Drip
- ○ Sinus Fullness
- ○ Snoring
- ○ Wheezing

CARDIOVASCULAR
- ○ Angina/Chest Pain
- ○ Breathlessness
- ○ Heart Murmur
- ○ Irregular Pulse
- ○ Swollen Ankles/Feet
- ○ Varicose Veins

URINARY
- ○ Bed Wetting
- ○ Hesitancy (trouble getting started)
- ○ Infection
- ○ Kidney Disease
- ○ Leaking
- ○ Pain/Burning
- ○ Prostate Infection
- ○ Urgency

MALE REPRODUCTIVE
- ○ Discharge From Penis
- ○ Ejaculation Problem
- ○ Genital Pain
- ○ Impotence
- ○ Prostate or Urinary Infection
- ○ Lumps in Testicles
- ○ Poor Libido (sex drive)

FEMALE REPRODUCTIVE
- ○ Breast Cysts
- ○ Breast Lumps
- ○ Breast Tenderness
- ○ Ovarian Cyst
- ○ Poor Libido (sex drive)
- ○ Vaginal Discharge
- ○ Vaginal Odor
- ○ Vaginal Itch
- ○ Vaginal Pain with Sex

PreMenstrual
- ○ Bloating Breast Tenderness
- ○ Carbohydrate Cravings
- ○ Chocolate Cravings
- ○ Constipation
- ○ Decreased Sleep
- ○ Diarrhea
- ○ Fatigue
- ○ Increased Sleep
- ○ Irritability

Menstrual
- ○ Cramps
- ○ Heavy Periods
- ○ Irregular Periods
- ○ No Periods
- ○ Scanty Periods
- ○ Spotting Between

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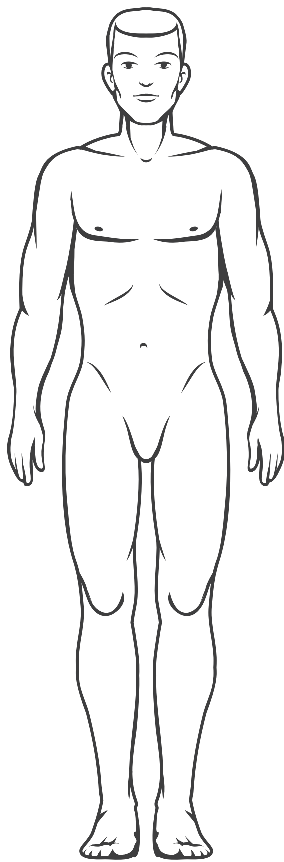
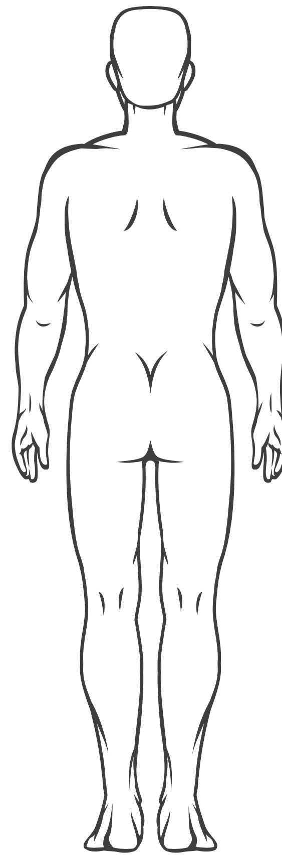
HEALTH & HISTORY QUESTIONNAIRE

WHOLE BODY SYMPTOM

Please mark any and all areas you are currently experiencing pain and/or discomfort with the corresponding symptom descriptions. If this does not apply to you, leave blank. *When using the Writable PDF, tab or click to select area then use your space bar to place text in appropriate area of discomfort.





Symptom Key:

0000	Numbness
TTTT	Tingling
XXXX	Burning
////	Stabbing
====	Aching
CCCC	Cramping
SSSS	Sensitive
PPPP	Other

Injuries and Pain Description: (Include any relevant dates and details of specific pain patterns and injuries.)

___

___

___