Lumin NUTRITION & WELLNESS

Health & Wellness History/Intake

Today's Date: ____/____/____

Name _____

Address _____

Phone _____

Chief Complaints/Why are you here? _____

_____

Wellness Goal _____

Height _____ Current Weight _____ Age _____

Blood Pressure _____ Bad Chol. _____ Good Chol._____

Are you under the care of an MD, DC or ND? YES ☐ NO ☐

If yes, whom? _____

Have you had a recent physical exam? YES ☐ NO ☐ When _____

Anything you need to report or would like us to know?

_____

_____

Family History: Diseases? What do relatives die from?

_____

Father's side

_____

Mother's side

_____

Any surgeries to report

_____

Known Allergies

_____

Last illness: Cold, Flu, etc.

_____

Energy Level:

Lowest 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ Highest

Sad ☐ grief ☐ moodiness ☐ anxious ☐ dreading ☐ frustrated ☐
angry ☐ panic ☐ crying ☐ feel flat ☐
Other: _____

Memory: Concentration ☐ word loss ☐ short term loss ☐

Appetite: Good ☐ OK ☐ cravings: sugar ☐ salt ☐

Currently taking vitamins/Minerals/formulas

_____

_____

Prescribed Medications/Pharmaceuticals

_____

_____

_____

Primary Problems (Please check boxes that apply to you)

HEADACHES: Temples ☐ cluster ☐ crown ☐ TMJ ☐ nausea ☐ behind eyes ☐

EARS: ringing ☐ plugged ☐ popping ☐ itching ☐ waxy ☐ loss ☐

EYES: Burning ☐ tearing ☐ red ☐ mucosa ☐ filmy ☐ floaters ☐ spots ☐ sensitive to light ☐

SINUS: Dry ☐ draining ☐ plugged ☐ smell loss ☐ taste loss ☐ sneezing a lot ☐

SORE THROAT: Hoarseness ☐ cough ☐ cankers ☐ blisters ☐ Halitosis ☐ dry mouth ☐

CHEST PAIN: palpitations ☐ murmur ☐ arm pain ☐

HEARTBURN: cramps ☐ nausea ☐ queasy ☐ bloating ☐ burping ☐

BOWELS: regular ☐ sluggish ☐ diarrhea ☐ constipation ☐ use of laxatives ☐ enemas ☐ other ☐

HEMORRHOIDS: Yes ☐ No ☐ occasionally ☐

DOES YOUR SKIN BRUISE EASILY?: Yes ☐ No ☐

PROSTATE: currently-burn ☐ ache ☐ pain ☐ restriction dribble ☐ swollen ☐

VAGINA: currently-burn ☐ dry ☐ pain with intercourse ☐
blood ☐ discharge ☐
Menses: regular ☐ irregular ☐ late ☐ early ☐ on the pill ☐ other contraceptive ☐
Flow: heavy ☐ moderate ☐ light ☐ long ☐ brief ☐
Cramps: mild ☐ med ☐ severe ☐ back ☐

PUFFY FACE ☐ hands ☐ feet ☐
BREAST TENDERNESS ☐ acne ☐ spotting ☐ clots ☐
PMS: moderate ☐ severe ☐ what kind: _____
DO YOU OVULATE? Yes ☐ no ☐ Fibroids ☐ Other:_____
MENOPAUSE: Do you have a uterus? yes ☐ no ☐ HRT yes ☐ no ☐
HOT FLASHES: Yes ☐ No ☐
DRY VAGINA: anxiety ☐ Other: _____
URINATION: Times up a night ___ Burn ☐ pain ☐ odor ☐ leaking ☐