Accunect

Keeping the U in Healthcare

Client Health and Wellbeing Intake Form

Name:
Email:
Address:
City, State, Zip:
Home Phone:
Other Phone:
Cellular Phone:
Referred by:
Date:
Date of Birth:
Age:

Part 1. Please answer the following questions to the best of your ability

Describe the problem(s) for which you seek help. Please include the dates when each problem occurred, and how long you have been experiencing the problem:

Please describe your past medical history (injuries, accidents, surgeries, illnesses, conditions) including approximate dates.

List the medications and supplements that you are presently taking, and the condition you are taking them for.

What daily activities are you finding difficult or are limited because of your above complaints?

What are your goals for the appointment?

Please list any other kind of health care professional you are seeing/have seen for this/these problem(s):

Please list any medical tests and results you have had within the past year:

Part 2. Please mark the symptoms that you experience

Digestion

☐ Loose stool or diarrhea
☐ Constipation
☐ Gas or belching
☐ Acid reflux
☐ Heartburn
☐ Stomach or intestinal pain
☐ Nausea/vomiting
☐ Difficulty digesting oil
☐ Blood in stool
☐ Poor appetite
☐ Excessive appetite
☐ Other:

Respiratory

☐ Allergies
☐ Asthma
☐ Dry cough
☐ Wet cough
☐ Catch colds easily
☐ Congestion nasal or chest
☐ Wheezing
☐ Other:
☐ Sinus problems
☐ Shortness of breath
☐ Chest tightness
☐ Do you smoke?
☐ Number per day_____
☐ Nose bleeds

Circulation Cardiovascular

☐ High blood pressure
☐ Low blood pressure
☐ Fast heart rate
☐ Slow heart rate
☐ Chest pain
☐ Palpitations
☐ Too hot
☐ Too cold
☐ Cold hands/feet
☐ Dizziness
☐ Water retention
☐ Other:

Urinary

- ☐ Painful urination
- ☐ Kidney infections
- ☐ Incontinence
- ☐ Other:
- ☐ Difficulty urinating
- ☐ Kidney stones

Other

- ☐ Difficulty learning
- ☐ Difficulty paying attention
- ☐ Difficulty with speech
- ☐ Development/growth issues
- ☐ Poor coordination
- ☐ Loss of balance
- ☐ Headaches
- ☐ Migraines
- ☐ Abdomen/thorax pain
- ☐ Numb/tingling. Where?_______
- ☐ Muscle weakness
- ☐ Difficulty walking
- ☐ Shaky
- ☐ Dry eyes
- ☐ Eye pain
- ☐ Watery eyes
- ☐ Poor vision
- ☐ Other eye problems?
- ☐ Thirsty
- ☐ No thirst
- ☐ Dry mouth
- ☐ Difficulty swallowing
- ☐ Anemia
- ☐ Eczema
- ☐ Skin condition
- ☐ Joint swelling
- ☐ Other
- ☐ Poor sense of taste
- ☐ poor sense of smell
- ☐ Poor hearing
- ☐ Fatigue
- ☐ Insomnia
- ☐ Lots of sleep. No hours? ____
- ☐ Nightmares
- ☐ Nose bleeds

Women Only

- ☐ Breast pain or tenderness
- ☐ Heavy or excessive flow
- ☐ Are your cycles regular?
- ☐ PMS
- ☐ Length of cycle:
- ☐ Other:
- ☐ Painful menses

Part 3. Wellbeing, Emotions and Stress

a: Please circle any of the following feelings you have experienced in the past few months.

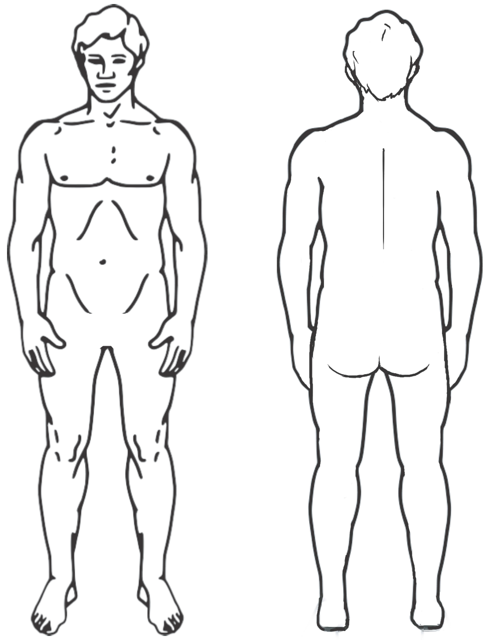
- ☐ Emotional
- ☐ Despair
- ☐ Helpless
- ☐ Uneasy
- ☐ Distress
- ☐ Fearful
- ☐ Angry
- ☐ Panic
- ☐ Guilty
- ☐ Sad
- ☐ Paranoid
- ☐ Muddled
- ☐ Grief
- ☐ Nervous
- ☐ Worried
- ☐ Restless
- ☐ Criticized
- ☐ Rejected
- ☐ Agitated
- ☐ Impatient
- ☐ Apprehensive
- ☐ Overwhelmed
- ☐ Intimidated
- ☐ Depressed
- ☐ Easily Irritated
- ☐ Unable to Grieve
- ☐ Overworked
- ☐ Persecuted
- ☐ Aggravated
- ☐ Uncertainty
- ☐ Annoyed
- ☐ Outraged
- ☐ Obsessive
- ☐ Indecisive
- ☐ Intolerant
- ☐ Paralyzed
- ☐ Hopeless
- ☐ Anxious
- ☐ Abused
- ☐

b: Please mark your level of stress from the listings below.

Family stress is:	☐ None	☐ Minimal	☐ Moderate	☐ Severe
Relationship stress is:	☐ None	☐ Minimal	☐ Moderate	☐ Severe
Work stress is:	☐ None	☐ Minimal	☐ Moderate	☐ Severe
Financial stress is:	☐ None	☐ Minimal	☐ Moderate	☐ Severe
Health stress is:	☐ None	☐ Minimal	☐ Moderate	☐ Severe
Other stress is: ____________________	☐ None	☐ Minimal	☐ Moderate	☐ Severe

Part 4. Pain.

Please mark areas of pain/discomfort on the body diagrams and make comments on the side if necessary.



Comments:

Client Signature: Date

Part 5 Practitioner to complete

List the notable symptoms with rating on a scale of 1-10. 1. Slight awareness of symptom. 3. Awareness of symptom as an aggravation. 5. Strong pain/symptom but still functional. 7. Strong pain/symptom unable to function. 10. Very serious, unbearable, take me to the emergency room.

Notable Symptoms	Comments – How often, when, where?	Rating
		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
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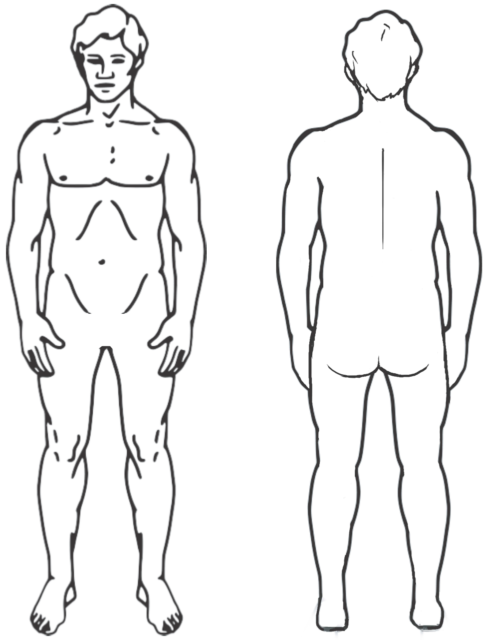
		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
		① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Comments and Notes



Practitioner signature: