Integrative Wellness LLC
info@ritanaomi.com

Name: Date:

Address: Phone:

Occupation: Date of Birth:

Medications: Contact Physician, Phone #

Allergies:

Emergency Contact Person, Phone #

Past Medical History: (Attach separate page if needed)
Before 1960 -

1961-70

1971-80

1981-90

1991-90

1991-00

2001-10

2011-present

Family History: Diabetes Cancer (specify below) Heart Disease
Alcohlism/Addictive Disorders Mental Illness (specify below)

List any other medical family related illness below

State in your own words any physical problems you are having:

What is your most comfortable body position? If you have any pain, what bodily position relieves it? If you are not sure, try different body positions until you find one that is most comfortable or relieves pain.

What do you think is the source of physical issues?

Have you had these issues before?

Which physical problems effect you the most?
Are you prevented from doing any of the physical activities below because of pain?

Walking?

Work?

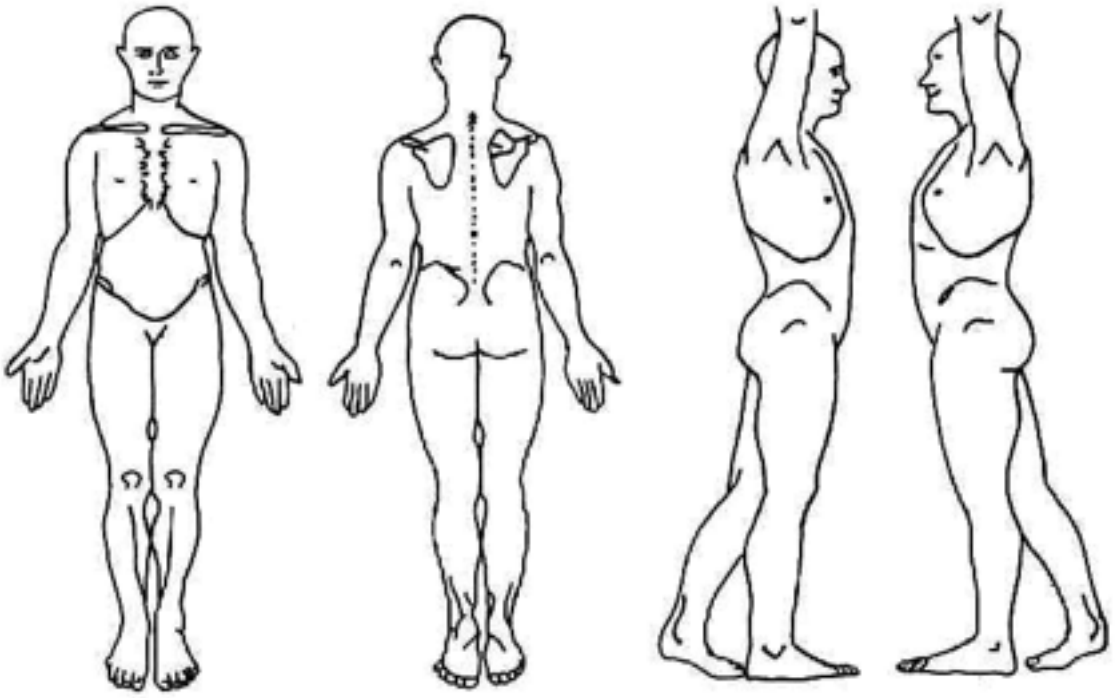
Driving?

Standing?

Sitting?

Exercising?

Shower/brushing teeth/other selfcare?



Describe any physical pain you are having. Mark on the form above where it is located. Please indicate 1. quality - examples: numb, tingling, sharp, 2. timing - constant, intermittent, day, night, morning, evening, 3. intensity on a scale of 1-10

On a scale of 1-10 with 10 the severest pain imaginable and 1 a mild headache, what is your current pain level? Circle one.

1 2 3 4 5 6 7 8 9 10

Do you have headaches? Yes No

If yes, are you aware of a pattern with your headaches?

Describe onset and duration, what you do to relieve the headache.

Female: Do you have irregular periods? Yes No Date of last one:

Tender breasts?

Pregnant?

Menopausal symptoms?

Have you been in any car accidents? Please describe and list symptoms or problems resulting from each accident. Include treatment and effect.

Are you or were you involved in a legal dispute related to the accident/s?

Do you exercise? Yes No Frequency:
Type of exercise:

Favorite exercises:

How long do you sit during the day?

What is the longest you stand during the day?

Do you go outdoors every day?

What are your goals for treatment?
1.

2.

3.

4.

5.