HALCYON HEALTH & WELLNESS, LLC

Name:

Address:

Email Address:

Primary Phone #:

Secondary Phone #:

***Emergency Contact**:

Date:

DOB: **Age**:

Gender: **Height**: **Weight**:

Occupation:

Employed: **Hours/Wk**: **Retired**:

Children:

Gender:

Ages:

Legal Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Domestic Partner

Living arrangement: ☐Alone ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends

How did you hear about Halcyon Health & Wellness? ______________________

Are you currently receiving healthcare? **Yes / No** If yes, who is/are your PCP / Specialist(s) / Alternative practitioners?

Please list health concerns:

1. ______________ 2. ______________
3. ______________ 4. ______________
5. ______________ 6. ______________
7. ______________ 8. ______________

Date of last physical exam: ______________

Date of last Blood tests: ______________

Date of last colonoscopy ______________

Date of last DEXA (bone density test) ______________

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Please check ALL that apply currently or previously and list approximate dates:

☐ Allergies ☐ Typhoid ☐ Cholera ☐ Food poisoning ☐ Worms ☐ Diarrhea ☐ Dysentery ☐ Blood clots ☐ Thyroid problem	☐ Measles ☐ German measles ☐ Chicken-pox ☐ Small-pox ☐ Mumps ☐ Whooping cough ☐ Prostate problems ☐ ED ☐ Low T	☐ Irregular menses ☐ PMS ☐ Miscarriage(s) ☐ Abortion(s) ☐ Endometriosis ☐ Fibroids ☐ Sickness during pregnancy ☐ Prolapse of uterus ☐ Breast lumps	**Circulatory:** ☐ High/Low Blood pressure ☐ Heart Failure ☐ Heart Murmurs ☐ Heart Attack ☐ Palpitation ☐ Giddiness ☐ Other ☐ Anemia ☐ Varicose Veins
☐ Asthma ☐ Cold-Fever ☐ Chill ☐ Pneumonia ☐ Pleurisy ☐ Rheumatic fever ☐ Scarlet fever ☐ Tuberculosis	☐ Major accident or injury to body or head ☐ Occasion of unconsciousness ☐ Major bleeding from any part of the body	**Venereal Disease:** ☐ Chlamydia ☐ Condylomata ☐ Gonorrhea ☐ Herpes ☐ Syphilis	☐ Kidney Stones ☐ Nephritis ☐ Diabetes ☐ Prostate ☐ Cancer ☐ Prostatitis ☐ AIDS
Operations: ☐ Tonsils ☐ Abdomen ☐ Appendix ☐ Hernia ☐ Uterus ☐ Renal stones ☐ Gallstones ☐ Phimosis ☐ Hydrocele ☐ Cataract ☐ Lasik ☐ Cosmetic **Mode of Anesthesia:** ☐ General ☐ Local **Antibiotics:** ☐ Never ☐ Less than once/yr ☐ More than once/yr ☐ Vaccine reaction	☐ Diphtheria ☐ Septic ☐ Tonsils ☐ Adenoids ☐ Recurrent infections ☐ Bronchitis ☐ Colitis ☐ Cystitis (Bladder) ☐ Eosinophilia ☐ Otitis Media (Ear) ☐ Pelvic infection ☐ Sinusitis ☐ Yeast Infection ☐ Candida ☐ Malaria ☐ Jaundice ☐ Any Liver, Spleen or Gall bladder disease ☐ Hepatitis ☐ Malnutrition ☐ Rickets ☐ Arthritis ☐ Gout ☐ Rheumatism ☐ Backache/problems	**Skin diseases:** ☐ Acne ☐ Allergy ☐ Boils ☐ Carbuncles ☐ Eczema ☐ Fungus ☐ Herpes ☐ Hives (Urticaria) ☐ Moles ☐ Ringworm ☐ Scabies ☐ Ulcers on body parts ☐ Warts ☐ Insomnia ☐ Nightmares ☐ Sleep disorder ☐ Anorexia/bulimia ☐ Binge eating ☐ Overweight ☐ Chemical Sensitivity ☐ Periodontal disease ☐ Glaucoma ☐ Hearing problems ☐ Hemorrhoids ☐ Hernia ☐ Phlebitis	☐ Serious shock ☐ Grief ☐ Disappointments ☐ Fright ☐ Mental upset ☐ Mental Illness ☐ Anxiety ☐ Depression ☐ Nervous breakdown ☐ Panic attack ☐ Psychotherapy ☐ Suicide attempt ☐ Alcohol/Drug problems ☐ Steroid use ☐ Chronic fatigue ☐ Chronic headaches ☐ Migraines ☐ Numbness ☐ Cramps ☐ Fits ☐ Neurological problems ☐ Seizures/epilepsy ☐ Convulsions ☐ Polio ☐ Paralysis ☐ Meningitis ☐ Any Lumbar Puncture

PAST HISTORY OF ILLNESSES, HEALTH CHALLENGES AND MEDICAL/SURGICAL PROCEDURES

Hospitalizations:	**Surgeries:**
Serious Illnesses & Injuries:	**Accidents, Traumatic Injuries, Broken Bones:**

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WOMEN Only

Date of last menstrual period: ________
Date of last pelvic exam: ________
Date/results of last pap smear ________
Ever had abnormal pap smear? ________
DES exposure ________
Sexually Transmitted Disease ________
History of sexual disease ________
Frequent yeast infections ________
Frequent bladder infections ________
Vaginal discharge ________
Age period began ________
Regular periods: Yes ☐ No ☐ ________
Flow: Heavy ☐ Medium ☐ Light ☐ ________
Length of cycle ________ Days of Flow ________ . ________
Spotting ☐ Cramps ☐ PMS ☐ ________
Endometriosis ☐ PID ☐ Fibroids ☐ ________
Ever used Birth Control pills? ________
How long for? ________
How long ago? ________
Present Birth Control ________
Change in sex drive ________
Painful intercourse ________
Pregnancies (number) ________
Childbirth (number) ________
Complications ________
Miscarriages (number) ________
Abortions (number) ________
Impaired fertility ________
Have you ever had a hysterectomy? ________
Age at Menopause ________
Vaginal dryness ________
Hot flashes ________
Do you do self breast exams? ________
Mammograms (number) ________
Date of last Mammogram ________

MEN Only

Date of last Prostate Exam ________
Prostate enlargement ________
Change in force of urine stream ________
Difficulty starting urination ________
Do you do self testicular exams? ________
History of undescended testicles ________
Pain / lump in scrotum ________
Discharge from penis ________
Painful intercourse ________
Difficulty with erections ________
Change in sex drive ________
Impaired fertility ________
Sexually Transmitted Diseases ________
History of sexual abuse ________

Worry and Anxiety: Do you have particular issues that worry you?

How does this impact your life?

Healthy relationships: Do you have a supportive family/community?

Unhealthy relationships: Have you been a victim of domestic abuse or troubling relationships?

Anything else you wish to discuss?

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Do you have any dietary restrictions or follow a particular dietary regimen? If yes, please describe: ______________________

____

____

Do you exercise? Yes __________ No ___________ What Type? ____

Frequency? __________________________________ Are you happy with amount? ________________________

Personal Habits:
Please indicate which substances, if any, pertain to you. Y = YES N = NO P = used in the PAST

Substance	Y/N/P	How Much?	How Long?
Tobacco			
Alcohol			
Rec Drugs			
Coffee			
Black Tea			

Substance	Y/N/P	How Much?	How Long?
Soda			
Diet Soda			
Artificial Sweeteners			
Refined Sugar			
Processed Food			

Do you need guidance/support with a healthy well-balanced diet? ____________________________________

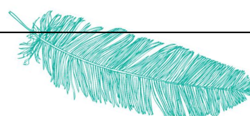
Do you have specific spiritual practice? Y_______N______ If so, please describe it:_______________________

____

LIFE CHANGES

In the past year, what changes have occurred in your:

Personal life:
Family life:
Social life:
Work life:
Sex life:



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FAMILY HISTORY:

	Age	If deceased, cause of death
Mother		
Father		

Siblings	Age	Deceased?

Check (double click box and select 'checked') items that apply to blood relatives and list relationship:

- ☐ Alcohol/drug problem ______
- ☐ Allergy/asthma ______
- ☐ Anemia ______
- ☐ Arteriosclerosis ______
- ☐ Arthritis ______
- ☐ Binge eating/bulimia ______
- ☐ Bleeding problem ______
- ☐ Cancer ______
- ☐ Diabetes ______
- ☐ Epilepsy/seizure ______
- ☐ Heart disease ______
- ☐ Skin disease ______
- ☐ High blood pressure ______
- ☐ High cholesterol ______
- ☐ Kidney disease ______
- ☐ Liver disease ______
- ☐ Mental illness ______
- ☐ Obesity ______
- ☐ Stroke ______
- ☐ Suicide ______
- ☐ Thyroid disease ______
- ☐ Tuberculosis ______
- ☐ Ulcer ______
- ☐ Syphilis ______
- ☐ Gonorrhea ______

Please list all prescription and over-the-counter medications you are currently taking:

Medication	Dose	Date Started	Prescribed By	Reason for Taking

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking:

Supplement	Dose	Date Started	Reason for Taking

Please list any severe or life-threatening allergies (include method of testing): ______________________________

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