



ADULT NEW MEMBER HEALTH SURVEY

Name _____ Sex: M F Pronouns _____ DOB ___/___/___ Age _____
E-mail _____@_____.com Phone _____
Address _____ City _____ State _____ zip _____
Partner's Name _____ Pronouns _____ Phone _____
Names of Child(ren) & Age(s) _____
How did you find our office? _____

Your genes are not your destiny; your environment determines what genes are turned on and how they express. Your biography becomes your biology.

We are going to ask you a variety of questions that give us more information about your past and present experiences. These experiences affect your physiology and directly affect your physical, mental, emotional and spiritual wellbeing. These experiences fall into four categories; physical (trauma), mental/emotional/spiritual (thoughts), electronic waves (technology), and chemical (toxins). If any experience was too much for your system to handle it can lock into your body as a tonal shift (tension) which can lead to a variety of symptoms. Please fill out the intake to the best of your ability. Your health survey is a key to the puzzle. No detail is too small.

YOUR ARRIVAL - *Your story starts with your conception, gestation and most importantly, your birth. The birth process can be very stressful on the birthing person's body but also on baby's.*

While in utero did your mother: Drink Smoke On Medication Use Drugs High stress Accident
Was your birth: Vaginal without assistance Vaginal with Assistance (Forceps Vacuum Extraction
 C- Section Induced labor Medications given _____

Where were you born? _____ Any complications? _____

CHEMICAL STRESS- *Anything you inhale, ingest, or absorb*

Are you currently taking/ have you taken birth control? How long? Type? _____
Current Medications (Name, Dose & Taken Since) : _____

Previous Medications & Vaccines (Name & When / how long taken) _____

Do You: Drink Alcohol _____x/ week Use Drugs Smoke _____packs/ week
 Drink Soda _____x/week Eat Packaged Food Use Air Purifier
 Coffee _____ per day Eat Organic _____% Use Water Filter
 _____oz of water per day Eat Non GMO Use Shower Filter

Current Diet: Vegetarian Pescatarian Vegan Keto Paleo Dairy-free Soy-Free Gluten-Free
 Other Chicken Fish _____x/ week Red Meat _____x/ week

What do your typical meals look like?

Breakfast: _____
Lunch: _____
Dinner: _____

EMOTIONAL/MENTAL STRESS: These stresses have a major affect on how our body processes and feels.

Occupation _____ Do you enjoy what you do: Y N S

Have you ever experienced the following?

- Mental Abuse Physical Abuse Sexual Abuse Major move Loss of a loved one
 Rapid life change Career change Being far from family/friends Financial Concern
 Divorce/ Separation Loss of Child Care provider for child/children Care Provider for parent

Please Explain: _____

PHYSICAL- *Thinking all the way back to your childhood, have you had any of the following?*

Surgery (& year performed) : _____

Accidents: _____

Falls: _____

Sports/ Exercise (past & present): _____

- Duties/Habits: Sit more than an hour Carry equipment or tools on your body Repetitive bend or twist
 Cradle the phone to ear L or R Drive on the Job Lift more than 10 lbs. repeatedly

Have you had a Breast Augmentation / Reduction / Removal? Y N (Please circle) Year(s) _____

Number of Previous Pregnancies: _____ Have you had a miscarriage or abortion? Y N When? _____

Type of birth(s): Vaginal Cesarean (planned - why? _____) _____ wks gestation

Birth Intervention(s): Induction: (Membrane Sweep Cytotec Ptocin Foley Balloon) Why? _____

Medication Antibiotics Epidural Ruptured membranes Ptocin Episiotomy Forceps / Vacuum

How long did you labor at home? _____ Hours Laboring _____ Time pushing _____

Did You: Delay Cord Clamp Skin to Skin right away Hemorrhage Baby was separated for _____ time

Complications with baby after birth Difficulty Delivering Placenta Baby latched right after delivery

Tearing Slow recovery Postpartum Blues Breastfeed - How Long? _____

Please provide a timeline of laboring/ birthing / Postpartum: _____

My Birth Experience was... _____

Are you Currently: Consciously Pre-Conceiving Conceiving Pregnant Guess (due) Date: _____

Conscious Conception? Y N Fertility Issues? Y N Fertility Measures Taken? Y N

Share Fertility Journey: _____

Third trimester presentation: Head Down Transverse Lie Breech Posterior Lie

Do you have: OBGYN Midwife Doula Lactation Consultant Postpartum Doula/ Baby Nurse

Have you experienced any of the following during this pregnancy: Morning Sickness/Vomiting/Nausea

Sciatic Pain Heartburn Bladder/ Kidney Infection Difficulty Sleeping Constipation

Low back Pain Headaches Pregnant with Multiples Gestational Diabetes Indigestion

Pubic bone Pain Varicose Veins Placental Dysfunction High Blood Pressure Hemorrhoids

CURRENT HEALTH CONCERNS

What is the reason for this reservation? _____

*Above each listed concern, please denote your current discomfort level on a scale of 1-10.

Is this discomfort level typical? If not, please describe the typical discomfort level: _____

When did this begin? _____ Have you had this before? _____

Why do you think this is occurring? _____

Is there any other issue/secondary condition that you believe is related to this? _____

Have you gotten any other advice or treatment for this issue? (if yes than from who and what was result)

What activities aggravate your condition? _____

What activities relieve your condition? _____

Is the condition worse during certain times of the day? Y N If yes, when? _____

Does it affect: Mood, patience, attitude Sleep exercise or play day-to-day activities Ability to work
 decision making relationship or intimacy

What are your healthcare goals? _____

SECONDARY CONDITIONS- Please mark any secondary condition (symptom/diagnosis) that you currently have or have had in the past. Secondary conditions are a result of your body compensating or adapting to your environment.

- | | | | | |
|--------------------------|--------------------------|------------------------------|--------------------------|---------------------------|
| Past | Now | | Past | Now |
| <input type="checkbox"/> | <input type="checkbox"/> | ADD/ADHD | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/ Respiratory Issues | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Athletic Injuries | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Back Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Bowel/Bladder Changes | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Concussion/ Head Injury | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental / Jaw issues / Braces | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Digestive Issues | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness / Vertigo | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear / Hearing Issues | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye / Vision Issues | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Cold / Flu | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue / Brain Fog | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | Herniated Disc |
| | | | | High Blood Pressure |
| | | | | Insomnia / Sleep Issues |
| | | | | Knee / Ankle / Hip Issues |
| | | | | Mastitis |
| | | | | Menstrual Problems / Pain |
| | | | | Multiple Sclerosis / ALS |
| | | | | Neck Pain |
| | | | | Numbness / Tingling |
| | | | | Reproductive Organ Issue |
| | | | | Scoliosis |
| | | | | Skin Condition |
| | | | | Sinus Problem / Allergies |
| | | | | Stroke |
| | | | | Surgery |
| | | | | Thyroid Disorder |
| | | | | Urinary Tract Infections |
| | | | | Weight Changes |
| | | | | Wrist / Elbow / Shoulder |
| | | | | Other _____ |

HEALTHCARE TEAM (PRIMARY CARE, THERAPISTS, SPECIALISTS etc)

Provider Name	Provider Type	Last Visit	Reason	Result
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Patient Signature _____ Date _____

