~Wired Wellness
Natural Health
CLINIC & SPA

FEMALE INTAKE FORM

We now offer a limited number of memberships (250) that allows up to 50% saving on almost all services in our clinic. Would you be interested in finding more information about becoming a member? YES NO

Name: _____ Date of Birth: _____ Age: _____

Sex: _____ Preferred Gender Pronouns: He/His/Him She/Her/Hers They/Them/Theirs Other:_____

Phone: _____ OK ***to leave detailed voicemail?*** **Y N**

Address: _____ City: _____ State: _____ Zip: _____

_____ (**Please Initial**) I consent to having documents, including but not limited to care plans, test results, photographs, and other relevant information, sent electronically to the following authorized e-mail address.

E-mail address: _____

In case of an emergency, please contact: _____ Relation: _____

Phone: _____ Address: _____

PAYMENT INFORMATION
Guarantor:
Name: _____DOB: _____ Employer: _____
Work Address: _____

Health insurance Co.
Name and address_____
Policyholder's name _____ ID_____
Telephone Number_____ Policy/Group # _____
Employer _____

_____ **(Please Initial)** I have Medicare. I understand Wired Wellness is not a Medicare provider and cannot bill Medicare or any secondary insurances thereafter. I will be responsible for the costs of my visits, procedures, lab work, and any other services provided at the time of service. I will also be responsible for the cost of lab testing which will be prepaid in office prior to completion.

If you DO NOT want to receive appointment reminders, holiday and promotional coupons, and occasional health news via e-mail, please check here. _____

Can we share information about your immunization information with other providers? Y N

MEDICAL HISTORY:
Please list Major Events (diagnosed conditions, hospitalizations, surgeries and date)
1._____ 2._____
3._____ 4._____
5._____ 6._____

CURRENT/ONGOING MEDICAL PROBLEMS AND HEALTH CONCERNS

Concern *please rank in priority	Onset i.e. June 1997	Frequency i.e. 4x/week	Severity i.e. mild/mod/severe
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list if YOU or any FAMILY MEMBERS who have had these conditions *(Siblings, Parents, Grandparents)* _____

Conditions:	Yes	No	Details
Heart Disease	O	O	_____
Hypertension	O	O	_____
High Cholesterol	O	O	_____
Lung disease	O	O	_____
Cancer	O	O	_____
Diabetes	O	O	_____
Hepatitis, Jaundice, Gallstones	O	O	_____
Digestive Problems	O	O	_____
Thyroid Disease	O	O	_____
Seizures	O	O	_____
Auto Immune Issues	O	O	_____
Stroke, Blood clots	O	O	_____
Headaches/Migraines	O	O	_____
Osteoporosis	O	O	_____
Ulcers	O	O	_____
Arthritis or Joint problems	O	O	_____
Persistent UTIs	O	O	_____
Sexually Transmitted Infections	O	O	_____
Depression	O	O	_____
Uterine fibroids/ovarian cysts	O	O	_____
Abnormal vaginal bleeding	O	O	_____
Endometriosis	O	O	_____
Fibrocystic breast	O	O	_____
History of Hysterectomy	O	O	_____
History of Oophorectomy	O	O	_____
History of tubal ligation	O	O	_____

Other:_____

Do you have any known contagious diseases at this time? Y N
If so, which? _____

Have you ever had the following? If so, please specify when.

Diphtheria: Year _____ Rheumatic fever: Year _____ Measles: Year _____ Mumps: Year _____
German measles: Year _____ Chicken pox: Year _____ Scarlet fever: Year _____

PREVENTIVE CARE:
Are you currently receiving healthcare? Y N
If so, where and from whom?_____
If not, when and where did you last receive medical or health care? _____
What was the reason? _____

What type of physical activity/exercise do you participate in? _____
Aerobic: _____min/day _____times/week **Anaerobic**: _____min/day _____times/week

SOCIAL HISTORY:

What is your occupation? _____
Do you like your job? Y N How long have you been at this occupation? _____
Have you recently been exposed to any toxins, infections, etc.?_____
What interests and hobbies do you have?_____
What are the major stressors in your life? _____
With whom do you live? _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

Do you use the following substances?

Substance	Never	Past	Current/Amount	Treated for addiction	Relapse
Alcohol	□	□	_____	_____	_____
Tobacco	□	□	_____	_____	_____
Other Drugs:	Which? _____		Frequency? _____		

NUTRITIONAL HISTORY:

Please list any foods that you exclude from your diet: _____
Why do you exclude these? _____
Are you a vegetarian/vegan? _____ How many years? _____
Do you eat organically grown foods? _____ Do you eat farm raised fish? _____
Do you drink coffee? (Please specify amount and what you add to it.) _____
Do you drink juice? (How much?) _____ Soda? (How much?) _____
How much water do you drink per day? _____ How many meals per day? _____
How often do you eat out? _____ How often do you go on diet? _____
What type of diet? _____

TYPICAL FOOD INTAKE

Breakfast: _____ Lunch: _____
Dinner: _____ Snacks: _____
Drinks: _____

IMMUNIZATIONS: (Circle)

	Polio	Tetanus	Measles/Mumps/Rubella	Diphtheria	Pertussis	Other
As a child:	O	O	O	O	O	O
As an adult:	O	O	O	O	O	O

ALLERGIES

(Medications, Foods, Others)	Reaction/What happens	Onset
1._____		
2._____		
3._____		
4._____		

CURRENT MEDICATIONS (include prescriptions, over-the-counter drugs, vitamins and supplements and birth control)

Medication Name	Reason for Taking	When Started	Dosage per Day

Briefly describe your goals for this visit: _____
_____
_____
_____

How does your condition affect you? _____
What do you think is happening? _____
Why? _____
What do you feel needs to happen for you to get better? _____
What do you enjoy most in your life? _____
How much change are you willing to make at this time in order to improve your health?
MINIMAL SOME COMPLETE
Any additional information? _____

PLEASE CIRCLE
Y=Yes, present condition **P=Past,** in the past **N=Never,** has never been an issue
Please add details or rate on the scale 1-10 when appropriate

GENERAL
Ht _____ Wt _____ Weight 1 year ago _____ Min Wt _____ Max Wt _____
Fevers: Y P, Chills: Y P, Weakness: Y P, Fatigue: Y P,
ENERGY
Morning ( ), Afternoon ( ), Evening ( ), Recent changes: Y N, Night sweats: Y P,
Loss of appetite: Y P, Insomnia: Y P, Excessive sleepiness: Y P, Average hrs/night slept _____,
Sleep well? Y N, Wake up rested? Y N, Interrupted? Y N, Difficulty falling asleep? Y N,
Difficulty staying asleep? Y N
MOOD
Generally happy? Y N, Mood swings? Y N, Anxiety? Y N,
Depressed? Y N, If so please explain _____
HEAD
Headaches: Y N P, Head Injury: Y N P, Dizziness: Y N P, Lightheadedness: Y N P
EYES
Recent vision changes: Y N P, Glasses/Contacts: Y N P, Eye pain: Y N P, Glaucoma: Y N P,
Cataracts: Y N P, Spots in the eyes: Y N P, Double vision: Y N P, Tearing/Dryness: Y N P
Date of last eye exam: _____
EARS
Recent hearing changes or loss: Y N P, Ringing: Y N P, Earaches: Y N P,

NOSE
Congestion: Y N P, Discharge: Y N P, Itching: Y N P, Nose Bleeds: Y N P, Loss of Smell: Y N P
MOUTH/THROAT
Dental Cavities: Y N P, Gum disease: Y N P, Dry mouth: Y N P TMJ: Y N P,
Frequent Sore Throats: Y N P, Hoarseness: Y N P, Gum Problems: Y N P
Sore mouth/tongue: Y N P, Change of taste in mouth: Y N P, Bad taste in mouth: Y N P
Last dental exam: _____
NECK
Pain or Stiffness: Y N P, Lumps: Y N P, Swollen Glands: Y N P, Goiter: Y N P
CARDIOVASCULAR
Chest Pain: Y N P, Low/High Blood Pressure: Y N P, Heart Murmur: Y N P,
Rheumatic Fever: Y N P, Palpitations: Y N P, Fainting: Y N P, Ankle Swelling: Y N P,
Blood Clots: Y N P, Stroke: Y N P, Shortness of Breath Lying down: Y N P
Date of last ECG: _____ Date of last Chest X-Ray: _____
RESPIRATORY
Seasonal Allergies: Y N P, Asthma: Y N P, Sinus Problems: Y N P, Post nasal Drip: Y N P,
Cough: Y N P, Sputum: Y N P, Coughing up blood: Y N P, Shortness of Breath: Y N P,
Shortness of breath w/ exertion: Y N P, Pain with breathing: Y N P, Chronic Bronchitis: Y N P,
Emphysema: Y N P, History of Tuberculosis: Y N P Positive PPD (TB skin test): Y N P
Date of last lung function test:_____
GASTROINTESTINAL
Difficulty swallowing: Y N P, Gas/Bloating: Y N P, Pain or Cramps: Y N P, Heartburn: Y N P,
Acid reflux: Y N P, Nausea: Y N P, Vomiting: Y N P Vomiting Blood: Y N P, Black Stool: Y N P,
Blood in Stool: Y N P, Hemorrhoids: Y N P, Constipation: Y N P, Diarrhea: Y N P,
Jaundice: Y N P, Liver Disease: Y N P, Gall Bladder Disease: Y N P, Hepatitis: Y N P,
Ulcers: Y N P, Bowel movements per day?_____ Is this a change? _____
Strain w/ BM: Y N P, Undigested food in stool: Y N P, Loose stools: Y N P, Narrow Stool: Y N P
Date of last colonoscopy: _____ Date of last endoscopy:_____
GENITOURINARY
Increase in frequency of urination: Y N P, Inability to hold urine: Y N P, Blood in urine: Y N P,
Pain with urination: Y N P, Increase in urine volume: Y N P, Reduced force of stream: Y N P,
Difficulty to initiate urination: Y N P, Dribbling urine: Y N P, Incontinence: Y N P,
Frequent UTIs: Y N P, Kidney Stones: Y N P, Urination at Night: Y N P
MUSCULOSKELETAL
Muscle Pain: Y N P, Arthritis: Y N P, Gout: Y N P, Backaches: Y N P, Neck pain: Y N P,
Significant Trauma: Y N P, Pain in hands/feet: Y N P, Crepitation: Y N P, Joint pain: Y N P,
Swelling: Y N P, Redness: Y N P, Stiffness: Y N P, Deformity: Y N P, Warmth: Y N P,
Limited range of motion: Y N P
NEUROLOGICAL
Fainting: Y N P, Dizziness: Y N P, Seizures: Y N P, Vertigo: Y N P Unstable gait: Y N P,
Limping: Y N P, Frequent falling: Y N P, Tremor: Y N P, Involuntary movement: Y N P,
Weakness: Y N P, Loss of muscle mass: Y N P, Paralysis: Y N P, Clumsiness: Y N P, Pain: Y N P,
Numbness: Y N P, Tingling: Y N P, Hypersensitive to pain: Y N P, Changes in Speech: Y N P,
Changes in handwriting: Y N P, Loss of short term/long term Memory: Y N P
BLOOD
Anemia, Y N P, Easy Bruising: Y N P, Enlarged Lymph nodes: Y N P, Clotting disorder: Y N P,
Bleeding disorder: Y N P, History of blood transfusions: Y N P, IV Drug use: Y N P

SKIN
Sores: Y N P, New growths: Y N P, Lumps: Y N P, New moles: Y N P, Color Changes: Y N P,
Acne: Y N P, Boils: Y N P, Ulcers: Y N P, Rashes: Y N P, Itching: Y N P, Dryness: Y N P,
Excessive sweating: Y N P, Changes/loss of Hair: Y N P, Changes in Nails: Y N P,
Changes in skin temperature: Y N P, Psoriasis: Y N P, Eczema: Y N P, Hives: Y N P
ENDOCRINE
Goiter: Y N P, Bulging eyes: Y N P, Heat Intolerance: Y N P, Cold Intolerance: Y N P,
Tremors: Y N P, Excessive sweating: Y N P, Palpitations: Y N P, Changes in voice: Y N P,
Changes in hair distribution: Y N P, Changes in secondary sex characteristics: Y N P,
Changes in body contour and weight: Y N P, Changes in hat/glove/shoe size: Y N P,
Excessive urination: Y N P, Excessive Thirst: Y N P, Excessive Hunger: Y N P,
Infertility: Y N P, Diabetes: Y N P, Hypoglycemia: Y N P, Thyroid condition: Y N P
PERIPHERAL VASCULAR
Muscle pain relieved by a short rest: Y N P, Leg cramps: Y N P**,** Cold Hands /Feet: Y N P,
Varicose Veins: Y N P, Clots in veins: Y N P
PSYCHIATRIC
Nervousness: Y N P, Tension/Stressed: Y N P, Anxiety: Y N P, Mood Swings: Y N P,
Panic attacks: Y N P, Depression: Y N P, Crying spells: Y N P,
Considered/Attempted Suicide: Y N P, Libido change: Y N P, Appetite change: Y N P,
Binge eating: Y N P, Purging: Y N P, Excessive exercising: Y N P, Paranoia: Y N P,
Hallucinations: Y N P, Disturbing thoughts: Y N P, Treated for Emotional Problems: Y N P,
Poor Concentration: Y N P

FEMALE REPRODUCTIVE
Age of First Menses_____ Cycles regular: Y N P, Spotting/Bleeding Between Cycles: Y N P,
Length of Cycle ____ Bleeding days____ Heavy Bleeding: Y N P,
Painful Menses: Y N P, if yes pain on a scale 1-10 ___,
PMS: Y N P, describe (I.e. mood swings, excessive hunger) _____
Vaginal discharge: Y N P, Itching: Y N P, Sores: Y N P, Masses: Y N P,
Sexually transmitted infections: Y N P, If Yes which one/s_____
Menopausal symptoms: Y N P, Dysfunctional uterine bleeding: Y N P, Endometriosis: Y N P,
Breast Tenderness: Y N P, Sexually Active: Y N P, Sexual Orientation_____
Sexual Difficulty: Y N P, Pain w/ Intercourse: Y N P, Difficulty Conceiving: Y N P,
Number of Pregnancies___ Number of Miscarriages____ Number of Live Births___ Number of
Abortions____ Any complication with pregnancy or delivery? ____ Are you pregnant now? Y N,
Are you breastfeeding now? Y N, Would you like to have more children? Y N,
Date of last menstrual Period _____ Date of last PAP :_____
Results:_____
Cervical Dysplasia Y N P, Details _____ Ovarian Cysts Y N P, Details_____

BREAST
Breast lumps: Y N P, Breast pain: Y N P, Nipple Discharge: Y N P
Date of last Mammogram: _____ Details: _____

Please circle if you have any of the following: sleep disruption, irritability, nervousness, mood swings, depression, anxiety, foggy thinking, decreased motivation, decreased self-confidence, loss of recent memory, headaches, cramps, breakthrough bleeding, hot flashes, night sweats, vaginal dryness, decreased sex drive, harder to reach climax, painful intercourse, urinary incontinence breast tenderness before period, fluid retention, fatigue dry skin, arthritis, hair loss, thinning hair, brittle nails, weight gain, inability to lose weight, elevated triglycerides, increased body/facial hair, acne, aches/ pains, fibromyalgia, infertility, chronic Illness, evening fatigue, morning fatigue, allergies, bone loss, susceptibility to infections, blood sugar imbalance, autoimmune illness, heart palpitations, constipation, cold hands and feet, menstrual irregularities, feeling cold all the time, hot/cold intolerance, elevated cholesterol, excessive thirst, excessive hunger, excessive urination, anemia, excessive bruising, excessive bleeding, diabetes, thyroid problems, change in glove and shoe size.

Please circle any of the following procedures that you'd like to learn more about.
Cellulite reduction, Scar/Stretch Mark treatment, Spider/Varicose Veins, Mesotherapy/Mesolift, *MesoBoost /Mesoglow,* PRP (Platelet Rich Plasma), Collagen Induction Therapy, Localized Fat reduction, Rejuv Vit Shots, IV Therapy, Hair Restoration, Bio puncture, Natural Pain Treatment, Phototherapy, Neural Therapy, Eliminating Excessive Sweating, Rosacea TX, Botox, Skin Rejuvenation/Wrinkle Reductions, Melasma Treatment, Age Spots/Sun Damage, Minimizing Pore Size, Improving Skin Tone/Texture /Color, Chemical Peels, Acne Solutions, Cosmetic Fillers, Enhancing and Defining Lips, Non-Surgical Face Lift, Micro Fat Injections, Laser Hair removal, Skin Care Information, Nutritional Balance, Bio- Identical Hormonal Balance, Medical Weight Loss, Naturopathic Medicine

Have you ever had your hormones levels tested? Y N
Have you ever had Hormone replacement therapy? Y N When? _____
Have you had problems with past HRT? Y N

If so, please explain: _____

Bone density scan: Y N P, Abnormal Y N P, When? _____
Do you remember diagnosis? _____

Date of last labs? (blood, urine, saliva, others)_____
Any abnormalities: _____

Signature: _____ Date: _____