LIVING WELL DALLAS | 14330 MIDWAY RD, SUITE 121, DALLAS, TX 75244 | 972-930-0260

First Name:	Last Name:	Date of Birth:
Prefer to be Called:	Marital Status (Circle): Single Married Partnered Widowed Separated	Age:
Street Address:	City:	State: Zip:
Preferred Phone (Circle): home work cell	Alternate Phone: home work cell	May we leave a message on your preferred phone? ❍ Yes ❍ No
Employer:	Occupation:	SS#
Emergency Contact Name: Emergency Phone(s):	Preferred email:	Primary Care Physician:
List any drug allergies:	Preferred Pharmacy:	List any food allergies:

What is your main reason for your visit today?

Which Services Interest You:

- ❍ acupuncture
- ❍ aromatherapy
- ❍ Biofeedback
- ❍ bio-identical hormones
- ❍ Bowen technique
- ❍ Chiropractic
- ❍ craniosacral therapy
- ❍ counseling/therapy
- ❍ detox program
- ❍ energy medicine
- ❍ energy medicine
- ❍ emotional freedom technique
- ❍ frequency specific microcurrent
- ❍ functional medicine
- ❍ food allergies testing
- ❍ health coaching
- ❍ Healing Touch™
- ❍ HeartMath™
- ❍ life coaching
- ❍ massage
- ❍ men's health
- ❍ nutritional testing
- ❍ metabolic blueprint
- ❍ nutrition counseling
- ❍ organization
- ❍ rapid eye technology
- ❍ Reiki
- ❍ walk & talk therapy
- ❍ wellness
- ❍ weight loss

Would you like to receive our newsletter? **❍ Yes ❍ No** *(we will never sell your name)*

Cancellation & Re-Scheduling Policy

We understand that there are times when you will need to cancel and/or reschedule your appointment due to emergencies. We will do our best to accommodate your needs in such situations.

Please know that all cancellations and/or rescheduling requests must be made at least two business days prior to the date of your appointment. If a previously scheduled session is not cancelled or rescheduled within 24 hours of the time of the appointment, that session will be "missed" and charged for the full session fee. Thank you for your understanding.

( ) I understand and accept this policy

______________________________ __________________

Your Signature **Today's Date**

Records and Privacy Policy: We will not release your records to anyone without your written consent. Because this is an integrated practice with multiple practitioners, we may facilitate care by having only one record per client. Coordinated care by your chosen practitioners will always be done with respect for your personal privacy and confidentiality.

( ) I understand and accept this policy

______________________________ __________________

NAME:______________________________ **DOB:** ______________

Name:______________________________ **DOB:**______________

How Well Do You Sleep? **How Long Do You Sleep?**	**Daily Stress Level** (Please Rate) ❍High ❍Moderately High ❍Average ❍None	**Daily Energy Level** (Please Rate) ❍Excellent ❍Good ❍Fair ❍Poor
Do You Exercise? What Type? How Often Per Week? For How Long?	**How Important is Religion/Spirituality to You and Your Family's Life**? ❍Extremely Important ❍Somewhat Important ❍Not At All Important	**Do You Drink Alcohol?** How Much Per Week? Do you Flush with Alcohol Intake?
Do You Use Recreational Drugs? How Much Per Week?	**Do You Smoke?** How Much Per Day? For How Many Years?	**Where have you lived and traveled?**
Previous Surgery and Dates: ❍Appendectomy Date: ____________ ❍Hysterectomy Date: ____________ ❍Tonsils/Adenoids Date: ____________ ❍Breast biopsy Date: ____________ ❍Back surgery Date: ____________ ❍Knee surgery Date: ____________ ❍Oral surgery Date: ____________ ❍Cesarean Section Date: ____________ ❍Tubal Ligation/Vasectomy Date: ________ ❍Other:__________ Date: ________ ❍Other:__________ Date: ________ ❍Other:__________ Date: ________ **Previous Injuries and Dates**: ❍Head Injury ____________ ❍Neck injury ____________ ❍Back injury ____________ ❍Bones Broken: ____________ **Previous Car or Tramatic Injury**: ❍Head Injury____________ ❍Neck injury ____________ ❍Back injury ____________ ❍Bones Broken: ____________	**Have You Been Diagnosed With:** ❍Anemia ❍Arthritis ❍Asthma ❍Bronchitis ❍Cancer type:____________ ❍Diabetes ❍Epilepsy ❍Gallstones ❍Gout ❍Heart Attack ❍Heart Failure ❍Heart Valve Problems ❍Hepatitis (Liver problem) ❍High Blood Pressure ❍High Cholesterol or Triglycerides ❍Irritable Bowel or Colitis ❍Kidney Stones ❍Mononucleosis ❍Plantar Fasciitis ❍Pneumonia ❍Rheumatic Fever ❍Sleep Apnea ❍Stroke ❍Thyroid Problems	**Do You Have or Wear:** ❍Glasses ❍Contact lenses ❍Hearing Aid(s) ❍Dentures ❍Pacemaker ❍Artificial knee(s) ❍Artificial hip(s) ❍Other: **How Often Have You Taken Antibiotics?** <5 times >5times Infancy/Childhood ❍ ❍ Teen ❍ ❍ Adult ❍ ❍ **How Often Have You Taken a Course of Oral Steroids?** <5 times >5times Infancy/Childhood ❍ ❍ Teen ❍ ❍ Adult ❍ ❍

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NAME:_______________________________________ **DOB:** ___________________

Any Other Hospitalizations and Dates:

Please describe your personal health history:

Family History: Please briefly describe any problems affecting your family below. If deceased, provide cause of death and their approximate age.

Mother – ____
Father – ____
Mother's Mother - ____
Mother's Father – ____
Father's Mother – ____
Father's Father – ____
Sibling(s) – ____
Spouse/Significant Other – ____
Child/Children – ____
Mother's Siblings – ____
Father's Siblings - ____

Ob-Gyn History *(Women Only)*

Are your periods regular? ____
Are your periods painful and/or symptomatic? ____
Have your periods changed recently? ____
Number of pregnancies total:_________________________
Number of miscarriages:______________________________
Number of abortions:________________________________
Current method of contraception:______________________
Date of last pap smear:_______________________________
Date of last mammogram/thermogram:_________________

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NAME:____ DOB: ____________________

Digestive Health

Do you have gas, bloating or heartburn?____

Has your digestion changed recently?____________

If so, in what way?____

How often do you have bowel movements?

❍more than 3 times a day ❍1-3 times a day ❍4-6 times a week ❍1-3 times a week

Which if any of these features describe your bowel movements?

❍soft ❍hard ❍float ❍sink ❍offensive odor ❍blood visible ❍difficult to pass ❍watery

With whom do you live?

How well have things been going for you?

	Very Well	Fair	Poor	Very Poor	Does Not Apply
With your attitude					
In your job					
At school					
In your social life					
With your close friends					
With your spouse					
With your boyfriend/girlfriend					
With your parents					
With your children					
With sex					

Have you or your family recently experienced any major life changes? If yes, please explain.

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NAME:______________________________ **DOB:** ____________________

Review of Symptoms: Please check if these symptoms occur presently or have occurred in the past 6 months. Note if the symptom is not applicable (n/a), mild, moderate or severe and add comments if indicated.

CATEGORY	SYMPTOM	SEVERITY								COMMENTS
	Cold hands/feet	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Cold intolerance	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Daytime sleepiness	❍	n/a	❍	mild	❍	moderate	❍	severe	
GENERAL	Difficulty falling asleep	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Waking early	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Fatigue	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Flushing	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Heat intolerance	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Night waking	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Nightmares	❍	n/a	❍	mild	❍	moderate	❍	severe	
	No dream recall	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Distorted sense of smell	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Distorted sense of taste	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Ear ringing/buzzing	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Eye crusting	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Eye pain	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Headache/migraines	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Hearing loss	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Vision problems	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Calf cramps	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Chest tightness	❍	n/a	❍	mild	❍	moderate	❍	severe	
MUSCLE	Foot cramps	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Joint deformity	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Joint pain	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Joint redness	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Joint stiffness	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Muscle pain/spasms	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Muscle twitches: eyes	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Muscle twitch: arms/legs?	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Muscle weakness	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Tendonitis	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Tension headaches	❍	n/a	❍	mild	❍	moderate	❍	severe	
	TMJ	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Anxiety	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Depression	❍	n/a	❍	mild	❍	moderate	❍	severe	
MOOD	Difficulty concentrating	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Difficulty with balance	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Difficulty with thinking	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Difficult with followthrough	❍	n/a	❍	mild	❍	moderate	❍	severe	

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NAME:____ DOB: ____________________

CATEGORY	SYMPTOM									COMMENTS
MOOD	Difficulty with judgment	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Difficulty with speech	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Difficulty with memory	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Dizziness	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Fainting/light headed	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Fearfulness	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Irritability	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Numbness	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Phobias	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Paranoia	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Seizures	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Suicidal thoughts	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Eating	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Bulimia	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Can't gain weight	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Can't lose weight	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Carbohydrate craving	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Poor appetite	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Salt craving	❍	n/a	❍	mild	❍	moderate	❍	severe	
DIGESTION	Bleeding gums	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Bloating in abdomen	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Blood/mucous in stool	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Burping/flatulence	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Canker sores	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Cold sores	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Constipation	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Diarrhea	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Difficulty swallowing	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Dry mouth	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Foods repeat(reflux)	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Heartburn	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Hemorrhoids	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Liver disease/jaundice	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Nausea	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Periodontal (gum) disease	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Strong stool odor	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Undigested food in stools	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Vomiting	❍	n/a	❍	mild	❍	moderate	❍	severe	
SKIN	Acne on face	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Athlete's foot	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Bumps - back upper arm	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Cellulite	❍	n/a	❍	mild	❍	moderate	❍	severe	

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NAME:____ **DOB:** _____________________

CATEGORY	SYMPTOM									COMMENT
SKIN	Dark circles under eyes	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Easy bruising	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Eczema	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Herpes	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Hives	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Oily skin	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Psoriasis	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Rash	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Shingles	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Skin cancer	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Strong body odor	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Vitiligo	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Dryness	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Enlarged lymph nodes	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Fingernails bitten	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Fingernails brittle	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Fungus fingernails/toenails	❍	n/a	❍	mild	❍	moderate	❍	severe	
	White spots fingernails	❍	n/a	❍	mild	❍	moderate	❍	severe	
RESPIRATORY	Sleep Apnea	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Nose bleeds	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Post nasal drip	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Sinus infections	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Snoring	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Breathlessness	❍	n/a	❍	mild	❍	moderate	❍	severe	
HEART	Heart attack	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Heart murmur	❍	n/a	❍	mild	❍	moderate	❍	severe	
	High blood pressure	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Irregular pulse	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Mitral valve prolapse	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Palpitations	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Phlebitis/blood clots	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Swollen ankles/feet	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Varicose veins	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Infection	❍	n/a	❍	mild	❍	moderate	❍	severe	
URINARY	Kidney disease	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Kidney stone	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Leaking/incontinence	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Pain/burning	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Urgency	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Prostate infection	❍	n/a	❍	mild	❍	moderate	❍	severe	
MALES	Discharge from penis	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Ejaculation problem	❍	n/a	❍	mild	❍	moderate	❍	severe	

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NAME:____ DOB: ____________________

CATEGORY	SYMPTOM									COMMENT
MALES	Genital pain	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Lumps in testicles	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Low libido(sex drive)	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Breast lumps	❍	n/a	❍	mild	❍	moderate	❍	severe	
FEMALES	Breast tenderness	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Ovarian cyst	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Low libido (sex drive)	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Endometriosis	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Fibroids	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Infertility	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Vaginal discharge	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Vaginal odor	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Vaginal itch	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Vaginal pain	❍	n/a	❍	mild	❍	moderate	❍	severe	
	PMS symptoms	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Menstrual cramps	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Heavy periods	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Irregular periods	❍	n/a	❍	mild	❍	moderate	❍	severe	
	No periods	❍	n/a	❍	mild	❍	moderate	❍	severe	
	Spotting between periods	❍	n/a	❍	mild	❍	moderate	❍	severe	

What percentage of the food you eat is home cooked? ____________%

Please list what you usually eat for:

Breakfast **Mid Morning Snack** **Lunch**

Afternoon Snack **Dinner** **Desserts**

Have you found certain foods do not "agree with you" or cause symptoms? If so, please identify the food and symptom you have.

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NAME:____ **DOB:** ____________________

MEDICATION	Mg./CC (strength)	Dosage (how much)	Date started	Date:____ list change

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NAME:____ **DOB:** ____________________

SUPPLEMENT	Mg./CC (strength)	Dosage (how much)	Date started	Date:____ list change