Inphinite Wellness

14912 Hull Street Rd.

Chesterfield Virginia 23832

Inphinitewellness.com

GENERAL INFORMATION:

Date_____________ Name ____ Date of Birth_________________________ Address______________________________________
City/State/Zip________________________ Home Phone_________________________________
Work Phone__________________________
E-Mail____ Occupation__________________________________
Employer______________________________ Status: S M D W Sep Spouse/Partner Name________________ Emergency Contact ____________________________
Phone_________________________________

Who may we thank for referring us to you?
____

MEDICAL HISTORY:

Please circle all conditions that apply and indicate any medications taken below:

Fibromyalgia Hepatitis Thyroid Disease Seizures HIV/AIDS Venereal disease Digestive disorders Tuberculosis Breathing problems Heart disease or Stroke High blood pressure High Triglycerides Cancer Lung disease Kidney disease Osteoporosis Ulcer Diabetes Mellitus Arthritis Anemia Neuromuscular disease Gallbladder disease Psychological challenges Other (please specify):____

Surgeries - please include year performed:
____ Hospitalizations:
____
Significant Trauma:
____ Known Allergies:
____

FAMILY MEDICAL HISTORY: (please specify family member)

________Cancer ________Diabetes ________Hepatitis ________Hypertension

________Heart disease ________Stroke________Asthma ________Alcoholism

________Miscarriage ________Autoimmune disease ________Other

MEDICATIONS:

Please list any medications you have taken within the last two (2) months. Include vitamins, OTC drugs, herbs, etc. and dosages. (use back of page if necessary)

OCCUPATION:

Do you usually work indoors or outdoors? Occupational stressors
(chemical, physical, psychological, etc):

PERSONAL:

Height: ________ Weight: ________

HABITS:

Do you smoke? _______ How much per day? _________ Since when? _______ Please describe any use of drugs for non-medical purposes:

Do you exercise regularly? ________ How many
hours do you sleep in general? _____

NUTRITION:

Do you drink caffeinated beverages? If so, how many per day?_________________ Do you drink alcoholic beverages? If so, how many per week?__________________ How much water do you drink per day? ______________________________________

Please describe your typical daily diet by indicating servings eaten of each group below:

________glasses of water ________fruits ________vegetables

________meats ________fast food ________coffee/tea/soda

________breads/grains/pastas

COMPLAINTS: (please circle all that apply)

Head Mouth Heart and Thorax Headaches Gum Problems Low blood pressure
Migraines Teeth Problems Tightness in chest Dizziness Tongue/lip sores
Arteriosclerosis Memory Loss Jaw clicking/pain Prior heart attack Unusual tastes
Palpitations High blood pressure Rapid Heart Beat, Eyes Throat Circulation
Blurred vision Difficulty swallowing Bruise easily Pain Sore throat Cold
hands/feet Dryness Enlarged thyroid Fainting Glasses Phlebitis Eyestrain
Varicose Veins Color Blindness Respiration Anemia Night blindness Asthma
Cataracts Bronchitis Skin Spots in front of eyes Chest pain Rashes Cough
Change in skin/hair Ears Coughing blood Dryness
Poor hearing Difficulty breathing Dandruff Ringing Phlegm Eczema Frequent ear
infections Pneumonia Hair loss Wheezing Hives Nose History of smoking Itching
Frequent colds Night sweats Sinus trouble Pimples Allergies Recent Moles
Nosebleeds Excessive sweating Drainage Gastrointestinal Men's issues
Emotional Poor appetite Prostate problems Depression Bad breath
Discharge Mania/Bipolar Excessive Hunger Impotence Anxiety Excessive
Thirst Frequent seminal emissions Bad temper Belching or Heartburn
Fertility problems Mood swings Gas Ejaculatory problems Stressed
Abdominal pain/cramps Painful/Swollen testicles Parasites Neuromuscular
Nausea Womens's issues Stiff neck Constipation Painful menstrual cycles
Low back soreness Chronic laxative use Cramps or backache Shoulder
trouble Loose stools or diarrhea Fertility problems Spinal curvature Blood
in stools Ovarian cysts Knee trouble Black stools Excessive flow Pain mid
back Hemorrhoids Endometriosis Swollen joints Rectal pain Light flow
Painful joints Stomach pain Clotting Hip pain Colitis or IBS Irregular cycle
Arthritis Gallbladder trouble Hot flashes Hand/wrist pain Vagina discharge
Knee pain Urogential Fibrocystic breasts Sprain Frequent urination Breast
tenderness Hernia Difficulty urinating PMS Sciatica Burning urination
Abnormal bleeding Numbness Frequent UTI's Low sex drive Paralysis
Waking to urinate # of pregnancies____ Retention of urine # of
births_____ Dribbling of urine # of miscarriages Bedwetting # of abortions
Pause of flow-urination Itching of genitals Energy Level Low energy Sleep
Excessive energy Insomnia Hard to wake up Drowsiness Energy drop
in afternoon Night sweats Sudden energy drops
Sleepwalking Excessive Dreaming Not enough
I have had an anaphylactic or other severe allergic reaction to the following substances: I have
been medically diagnosed for the following allergies/asthma: