

NEW PATIENT EVALUATION
HEALTH AND WELLNESS OF CENTRAL FLORIDA

Today's Date: _____ Referred by: _____
Name: _____ M F Birthdate ____ / ____ / ____ Age ____
Mailing Address: _____
City: _____ State: _____ Zip: _____ Occupation: _____
Marital Status: S M D W No. of children: _____
Daytime phone: _____ Evening phone: _____
Email: _____

1. **Complaints** Please tell us the main reason why you are here _____

2. **Secondary Complaints** Please let us know any other health concerns that you have _____

3. **Previous Treatment for these Complaints** _____

4. **Medications** Please let us know all prescription medications you are taking _____

5. **Major Illnesses** Please list any major illnesses and approximate dates _____

6. **Surgeries** Please list any surgeries and approximate dates _____

7. **Injuries** Please list any accidents or injuries, and approximate dates _____

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8. WOMEN ONLY

Are you pregnant: _____ Are you nursing? _____

Date of onset of last menstrual period: _____

Any gynecologic surgeries (hysterectomy, endometriosis, ovarian cysts)? _____

Menstrual Cycle Do you have regular monthly periods? _____

Circle any of the following symptoms you experience associated with your period:

Cramping bloating moody cravings heavy bleeding back pain Headaches clots

9. **Sleep** (please circle) Trouble falling asleep Can't stay asleep Bad dreams
Any other sleep problems? _____

10. **Pets** Any pets? _____ If so, what kind and how many? _____

11. **Exercise** What kind of exercise do you do? _____
How often? _____ Duration _____

12. **Food Allergies** Please list _____

13. **Food Cravings** Please circle answers to the following questions about food
cravings, regardless of whether or not you let yourself eat these foods:

a. If you could have any breakfast that you wanted, which would you choose:

Poached eggs with hollandaise sauce

Bacon and eggs

Granola and yogurt

Toast and oatmeal and coffee or tea

b. If you could have any lunch that you wanted, which would you choose?

Barbecued ribs or teriyaki and chips

Hamburger and French fries

A cheese sandwich and/or a milkshake

A sandwich, pretzels and a soda or coffee

c. If you could have any dinner that you wanted, which would you choose?

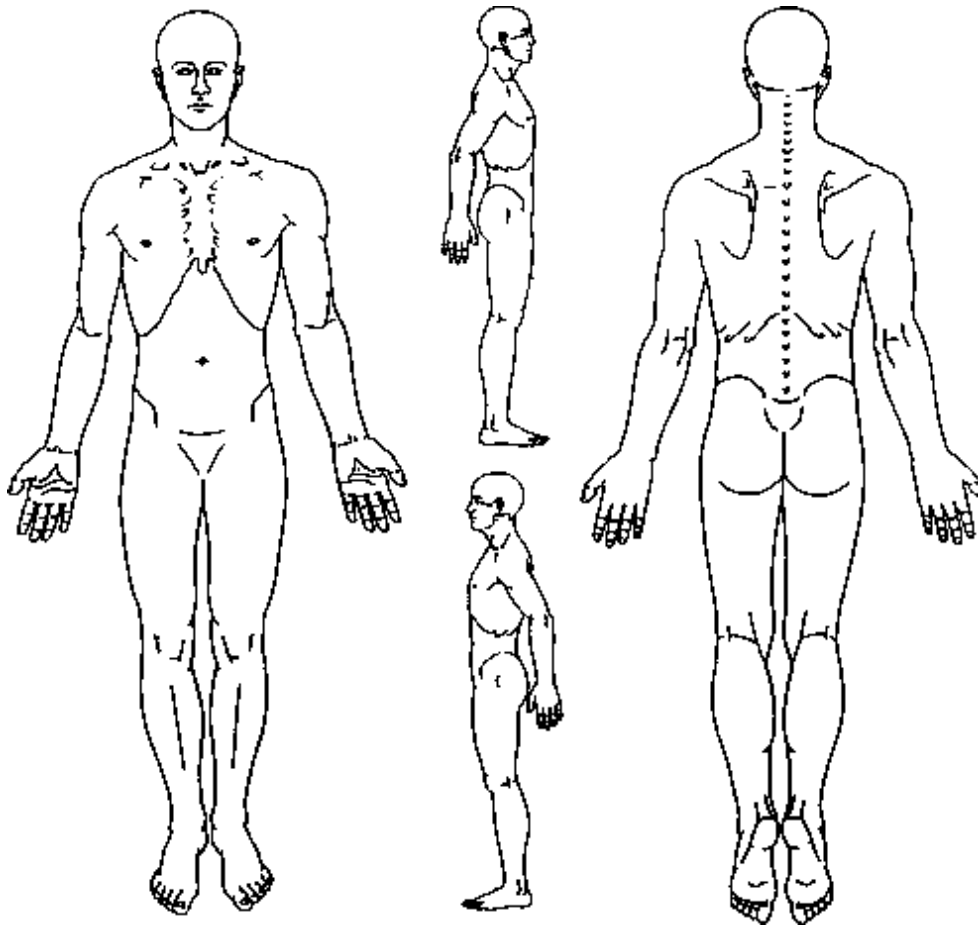
Thai food

A nice steak Pizza




Pasta with sauce

TRAUMA HISTORY

HEALTH AND WELLNESS OF CENTRAL FLORIDA



DIRECTIONS

	<p>Scars</p>	<p>Please draw a zig-zag over areas where you have scars, even if they are very old or difficult to see. Don't forget C-sections, episiotomies, vaccination scars, surgeries, body piercings, tattoos, cosmetic surgeries, vasectomies, stretch marks, etc. Please note the approximate age you were when you got each scar.</p>
	<p>Surgery</p>	<p>Please circle the location of any surgeries, including exploratory surgeries, laparoscopies etc. Please write the year of the surgery on the drawing.</p>
	<p>Internal Metal</p>	<p>Please put a square around any internal metal objects, such as surgical pins, metal plates, hip replacements etc.</p>