The Virginia Center for Health and Wellness
39070 John Mosby Hwy/ PO Box 107 Aldie VA 20105
Phone: 703-327-2434 Fax: 703-327-2729

Patient Name:_____ Date of Birth:_____

How did you hear about us? _____

What is the reason for your visit?

Please list your primary care physician, specialists and any other healthcare providers you have seen. Please include phone numbers.

Please list symptoms that keep you from feeling as well as you would like:

What diagnoses have you been given?

Have you ever been hospitalized?
If yes, when and why?

Are you taking any pharmaceutical or homeopathic medications and or nutritional supplements? (Please list all)

Please list all allergies including food, medication and environment.

Please describe your food and liquid intake in detail (eating habits):

the Virginia Center for Health & Wellness

Family History:

Mother: Living/Deceased (circle one) age_____
Health problems?

Father: Living/Deceased (circle one) age_____
Health problems?

Siblings: Living/Deceased (circle one) age_____
Health problems?

Living/Deceased (circle one) age_____
Health problems?

Living/Deceased (circle one) age_____
Health problems?

Extended family: are there any conditions shared by 2 or more blood relatives?

Number of pregnancies _____ Number of children _____ Number of miscarriages _____

Number of abortions _____

General Questions

Please circle yes or no with a brief description for all "yes" answers

Y N Do you have Fatigue more than average for your activity?

Y N Do you often feel anxious?

Y N Do you feel sensitivity to the heat or cold?

Y N Do you have cold hands or feet?

Y N Do you feel pain in any part of your body?

Y N Do you have skin or hair changes including rashes?

Y N Do you have difficulty with memory?

Y N Have you experienced fainting, dizziness or difficulty moving any part of your body?

Y N Do you have any numbness or unusual sensations in your body?

Y N Do you have asthma or breathing difficulty at rest or with exertion?

Y N Do you have a history of pneumonia, emphysema, or other lung problems?

Y N Do you have a history of antibiotic use?

Y N Do you have chest pain at rest or with activity?

Y N Do you have swelling in your ankles, feet or other part of your body?

Y N Do you have palpitations, heart racing and or skipping beats?

Y N Do you have gas, bloating, diarrhea, constipation, or abdominal pain?

Y N Do you have pain or stiffness in your muscles, bones or joints?

Y N Do you have fatigue after eating? If yes, what types of foods?

Y N Do you have hemorrhoids?

Y N Do you have frequent urination?

Y N Do you have pain or burning during urination?

Y N Do you have a history of Urinary Tract Infections?

Y N Do you have a change in libido (increase/decrease sexual desire?)

Y N WOMEN: Do you have menstrual or reproductive difficulties?

Y N Do you or did you smoke? How much? How long?

Y N Do you drink alcohol? How much per week?

Y N Do you use drugs, recreationally or otherwise?

Y N Do you have difficulty sleeping?

Y N Do you have silver fillings (amalgams) in your mouth?

Y N Have you ever had root canals? How many? When?

Y N is there anything else you would like us to know?

Please list any individuals you authorize us to discuss your medical information: