Next Step Health and Wellness

Phone 281-318-5777| Fax: 281-318-5778

We ask that you complete each page of the enclosed comprehensive initial consultation form and return it to us at your initial appointment. If it is convenient for you, we also request the following:

> Any laboratory results for previous 1 year– Complete Blood Count (CBC), Comprehensive Metabolic Profile (CMP), Cholesterol Panel (HDL, LDL, Total Cholesterol), any thyroid and/or hormone studies, any special food sensitivity testing, saliva, and/ or stool testing.

If you are not conveniently able to locate these items and your clinician would require them to continue care, we will have to complete an authorization to release medical records form at your first appointment to obtain them. If these tests have not been completed recently, our clinician will let you know what she feels is necessary for you at the time of your appointment.

We also ask that you bring the following to your initial consultation:

1. Photo ID
2. Medication and supplement list

Please arrive 15 minutes prior to your appointment. If you arrive 10 minutes or more PAST your scheduled appointment time, you may be asked to reschedule to maximize your time with your clinician. If you are unable to keep your appointment, please call at least **24 hours in advance** of your scheduled appointment date to cancel or reschedule. **Please know that we are unable to provide supervision for young children that accompany you to our clinic and we ask that you make other arrangements.**

We greatly appreciate our patients, and work hard to ensure each patient is our top priority during appointments. We make every effort to respond to questions and / or concerns presented outside of an appointment within 3-5 business days.

Thank you for allowing us to be a part of your health care team. We look forward to meeting you soon!

Wellness is Waiting!

DEMOGRAPHIC PROFILE

Please complete to the best of your knowledge and return to our clinic at your initial appointment.

Today's date:_____

Legal Name:_____Preferred Name:_____

Date of birth:_____Sex:_____ Ht:_____Wt: _____

Address:_____City: _____ State:_____ Zip: _____

I wish to be contacted in the following manner (check all that is acceptable):

☐ Cell Phone: _____ ☐ Check if we may leave a detailed message (test, results, billing, etc.)

☐ Home Phone: _____ ☐ Check if we may leave a detailed message (test, results, billing, etc.)

☐ Work Phone: _____ ☐ Check if we may leave a detailed message (test, results, billing, etc.)

My Email Address: _____

(By providing your e-mail address, you are giving your consent for future email communication from Next Step Health and Wellness. They may use this email through to send you email newsletters, promotions and discounts, and for marketing their events. You may request to have your email address removed from this list at any time.)

Legal Guardian (if applicable):_____ Relationship to patient: _____

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

Cell Phone:_____ Home Phone: _____ Work Phone: _____

Pharmacy:_____ Phone:_____

Primary Care Provider:_____ Phone: _____Fax: _____

Alternative Providers (i.e. Chiropractor):_____ Phone:_____

Please list your race:

□White □Asian □Black or African American □American Indian or Alaska Native

□Native Hawaiian or Other Pacific Islander □Other □Unreported/Refused to Report

COMPREHENSIVE HEALTH INFORMATION

How did you hear about us?

_____

(If recommended by a current patient, please state who so we can send them a token of our appreciation.)

Reason for your visit:_____

Social History:

☐Smoke – Packs per day? _____

☐History of smoking, date quit:_____

☐Marijuana

☐Other drugs

☐Caffeine how may times per day?____

☐Alcohol

☐Sleep – Hours per night? ____

☐Exercise_____x/week

☐Employed

☐Unemployed

☐Occupational exposures

☐Disabled

Occupation:_____ Marital Status:_____

FAMILY MEDICAL HISTORY

List any family relations that have had a history of the diseases below. For example, if your grandmother on your mother's side had diabetes, find diabetes in the Disease list and write "Maternal Grandmother".

Diseases (write relative in the blank if they had the disease)

Alzheimer's _____

Osteoarthritis _____

Celiac Disease _____

Diabetes _____

Glaucoma _____

High Blood Pressure _____

Liver Disease _____

Osteoporosis _____

Tuberculosis _____

Hypothyroid _____

Cancer _____

Anemia _____

Asthma _____

Depression _____

Epilepsy _____

Heart Disease _____

Infertility _____

Mental Illness _____

Stroke _____

Autoimmune Disease _____

Multiple Sclerosis _____

Rheumatoid Arthritis _____

Past Medical History:

☐Alzheimer's	☐Anemia	☐Anxiety	☐Arthritis	☐Asthma
☐Back Injury	☐Bladder tumor	☐Bleeding problems	☐BPH	☐Bronchitis
☐Cancer	☐Cataracts	☐Celiac	☐Chest Pain	☐Constipation
☐COPD	☐Cysts (ovarian)	☐Depression	☐Diabetes	☐Diverticulitis
☐Dysmenorrhea	☐Endometriosis	☐Falls	☐Fertility problems	☐Fibroids
☐Fractures	☐Glaucoma	☐Headaches	☐Head Injury	☐Heart attack
☐Heart disease	☐Hemorrhoid	☐HIV/AIDS	☐Hypertension	☐Thyroid Disease
☐Incontinence	☐Irritable bowel	☐Kidney stones	☐Liver disease	☐Mental health
☐Multiple sclerosis	☐Osteoporosis	☐Parkinson's	☐PCOS	☐Pneumonia
☐Prolapse vaginal	☐Prostate issues	☐Pulmonary emboli	☐Renal disease	☐Sinusitis
☐Skin sensitivities	☐Spinal cord injury	☐STDs	☐Stroke	☐Seizures
☐Vascular problems	☐Heart murmur	☐Urinary Infection	☐Other_____	

Past Surgical History:

☐Bladder suspension	☐Pacemaker	☐C-section	☐Cataracts	☐Cardiac related
☐Polyps	☐Hemorrhoids	☐Joint replacement	☐Hysterectomy	☐Ovaries removed
☐Other_____				

Health Promotion/Screenings:

Have you had any of these in the past year?

☐ Vision check ☐ Dental Visit ☐ Yearly Exams ☐ Pap ☐ Mammogram

☐Bone Density Scan, Year_____ ☐Colonoscopy, Year _____ ☐EKG, Year _____

☐Last lab work, Year_____ ☐Perform breast self-exams ☐Perform testicular self-exams

Allergies: State whether mild, moderate, or Severe

Drug Allergies_____

Food Allergies: _____

Current Medications:

Medication	Dosage	Frequency	Who prescribed it?

Current Nutritional / Herbal Supplements: *Please bring supplements or a copy of the Ingredients to your visit*

Supplement	Dosage	Frequency	Who prescribed it?

Female

☐Breast lumps ☐Breast tenderness ☐Nipple discharge ☐Decreased libido

☐Vaginal dryness ☐Vaginal discharge ☐Vaginal bleeding ☐Vaginal sores

☐Painful cycles ☐Pelvic pain ☐Abnormal PAP ☐Abnormal mammogram

☐Pregnancy #____ ☐Miscarriage#___ ☐On birth control ☐PMS symptoms in second half of cycle

☐STDs

Last menstrual period_____ Are you trying to get pregnant?_____

If not currently trying to get pregnant, what is your method of pregnancy prevention?_____

Have you had a hysterectomy? ☐ Yes ☐ No If yes, were your ovaries removed? _____

Have you taken hormone replacement therapy (HRT)? ☐ Yes ☐ No If yes, which kind? _____

Please check the routes that you have taken of HRT: ☐ Oral pills ☐ Patch ☐ Gel/cream ☐ Sublingual troche ☐ Vaginal ring

Your age when you began menopause_____ Year you began menopause _____

Any other information we should know? _____

_____

Male

☐Testicular mass ☐Testicular pain ☐Erectile dysfunction ☐Decreased libido

☐Penile sores ☐Change in urine stream ☐Prostate problems ☐STDs

☐Penile discharge

Any other information we should know?_____

_____

Pain

If you have pain, what is the location of your pain? _____

On a scale of 0-10 with 10 being the worst pain imaginable and 0 being no pain, rank your pain: _____

REVIEW OF SYSTEMS

Circle Yes or No

Constitutional

Hot Flashes	Yes	No
Sleeping problems	Yes	No
Night Sweats	Yes	No
Weight Loss/gain	Yes	No
Fatigue	Yes	No

Eyes/Ears/Throat

Vision changes	Yes	No
Dry Eyes	Yes	No
Difficulty hearing	Yes	No
Ringing in ears	Yes	No
Vertigo	Yes	No
Sinus problems	Yes	No
Sore throat	Yes	No

Cardiac		
Murmur	Yes	No
Chest pain	Yes	No
Dizziness	Yes	No
Ankle swelling	Yes	No
Palpitations	Yes	No

Endocrine	Yes	No
Loss of hair		
Heat/cold intolerance	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No

Gastrointestinal	Yes	No
Heat burn	Yes	No
Nausea/vomiting		
Constipation	Yes	No
Diarrhea	Yes	No
Abdominal pain	Yes	No

Genitourinary		
Increased urination	Yes	No
Blood in urine	Yes	No
Abnormal discharge	Yes	No

Hematology		
Easy Bruising	Yes	No
Swollen Glands	Yes	No
	Yes	No

Musculoskeletal		
Joint pain/swelling	Yes	No
Stiffness	Yes	No
Muscle pain	Yes	No
Back pain	Yes	No

Neurological		
Loss of strength	Yes	No
Numbness	Yes	No
Headaches	Yes	No
Tremors	Yes	No
Memory loss	Yes	No

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Loss of strength	Yes	No
Numbness	Yes	No
Headaches	Yes	No
Tremors	Yes	No
Memory loss	Yes	No

Skin		
Rash/sores	Yes	No
Lesions	Yes	No
Itchiness/burning	Yes	No
Acne	Yes	No

Psychiatric		
Anxiety/Depression	Yes	No
Mood Swings	Yes	No
Difficulty sleeping	Yes	No