

*Well Within*  
**NEW PATIENT INFORMATION FORM**

Please print clearly:

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

Circle the best way to reach you. I can receive calls after \_\_\_\_\_ am & before \_\_\_\_\_ pm

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

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Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status: S M D W

Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex: M F Blood Type \_\_\_\_\_

Overall health (circle one): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_

Referred by: \_\_\_\_\_

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CHIEF CONCERNS (reasons you are here in order of importance)

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

Previous treatments for these complaints:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

Other concerns or problems: \_\_\_\_\_

Are you currently under the care of physicians or other health care professionals? Y N

Physician's names & dates of last visits: \_\_\_\_\_

Do you smoke, drink coffee, caffeinated beverages or alcohol? (if yes, how much)

Cigarettes \_\_\_\_\_ Coffee \_\_\_\_\_ Alcohol \_\_\_\_\_

Sodas \_\_\_\_\_ Tea \_\_\_\_\_ Other Caffeine \_\_\_\_\_

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How can we help you feel *well within*? \_\_\_\_\_

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

*Well Within*  
*Health Restoration Center*

401 Fourth Avenue  
Indialantic, FL 32903

(321) 724-1212  
www.WellWithinUs.com

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## **New Patient Introduction & History Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Please list any vitamins, herbs, or supplements you currently take.  No supplements
  
2. Please list any medications you are taking, include the date you started and why you are taking them.  No medications
  
3. Please list any allergies or sensitivities you have.  No allergies
  
4. Please list any surgeries or medical procedures you have had in the past 12 months.  No recent surgeries
  
5. Please list any other surgeries or procedures you have ever had, including dates.  No other surgeries
  
6. Please list any major illnesses with approximate dates.  No major illnesses
  
7. Please list any accidents or injuries with dates and treatments.  No injuries/accidents
  
8. Please list any major events, traumas or changes in your life in the past 5 years, including dates.  No major events

# FAMILY HEALTH HISTORY

NAME: \_\_\_\_\_ Date: \_\_\_\_\_

Please review the below listed conditions and diseases and indicate those that apply as follows:  
 Mark “**C**” in his/her column if it is a CURRENT health problem, or  
 mark “**P**” if this is a PAST health problem, or leave blank if it does not apply.

	Self	Father	Mother	Spouse	Brothers			Sisters			Children		
<b>Age</b>													
<b>CONDITION</b>													
Alzheimer’s													
Arthritis (Type: _____)													
Asthma-Hay Fever													
Back Trouble													
Bursitis													
Cancer (Type: _____)													
Constipation													
Diabetes													
Disc Problem													
Emotional Problems													
Emphysema													
Epilepsy													
Headaches													
Heart Trouble													
High Blood Pressure													
Insomnia													
Kidney Trouble													
Liver Trouble													
Migraines													
Nervousness/Anxiety													
Neuritis													
Parkinson’s													
Pinched Nerve													
Sinus Trouble													
Stomach Trouble													
Thyroid Problems													
Other:													

If any of the above family members are deceased, please list their age at death and cause of death:

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# SYMPTOM SURVEY FORM



Patient \_\_\_\_\_ Doctor \_\_\_\_\_ Date \_\_\_\_\_  
 Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Approx Weight \_\_\_\_\_ Sex: Male \*\* Female \*\*  
 Pulse: Recumbent \_\_\_\_\_ Standing \_\_\_\_\_ Vegetarian: Yes \*\* No \*\*  
 Blood pressure: Recumbent \_\_\_\_ / \_\_\_\_ Standing \_\_\_\_ / \_\_\_\_ Ragland's Test is Positive \*\*

**INSTRUCTIONS:** Fill in only the circles which apply to you.  
   MILD symptoms (occurred once or twice last 6 months).  
   MODERATE symptoms (occurred once or twice last month).  
   SEVERE symptoms (chronic, occurred once or twice last week).  
   Leave circles **BLANK** if they don't apply to you!

- 1 2 3 GROUP 1**
- 1    Acid foods upset
  - 2    Get chilled often
  - 3    "Lump" in throat
  - 4    Dry mouth-eyes-nose
  - 5    Pulse speeds after meal
  - 6    Keyed up - fail to calm
  - 7    Cut heals slowly
  - 8    Gag easily
  - 9    Unable to relax; startles easily
  - 10    Extremities cold, clammy
  - 11    Strong light irritates
  - 12    Urine amount reduced
  - 13    Heart pounds after retiring
  - 14    "Nervous" stomach
  - 15    Appetite reduced
  - 16    Cold sweats often
  - 17    Fever easily raised
  - 18    Neuralgia-like pains
  - 19    Staring, blinks little
  - 20    Sour stomach often
- GROUP 2**
- 21    Joint stiffness on arising
  - 22    Muscle-leg-toe cramps at night
  - 23    "Butterfly" stomach, cramps
  - 24    Eyes or nose watery
  - 25    Eyes blink often
  - 26    Eyelids swollen, puffy
  - 27    Indigestion soon after meals
  - 28    Always seems hungry; feels "lightheaded" often
  - 29    Digestion rapid
  - 30    Vomiting frequent
  - 31    Hoarseness frequent
  - 32    Breathing irregular
  - 33    Pulse slow; feels "irregular"
  - 34    Gagging reflex slow
  - 35    Difficulty swallowing
  - 36    Constipation, diarrhea alternating
  - 37    "Slow starter"
  - 38    Get "chilled" infrequently
  - 39    Perspire easily
  - 40    Circulation poor, sensitive to cold
  - 41    Subject to colds, asthma, bronchitis
- GROUP 3**
- 42    Eat when nervous
  - 43    Excessive appetite
  - 44    Hungry between meals
  - 45    Irritable before meals
  - 46    Get "shaky" if hungry
  - 47    Fatigue, eating relieves
  - 48    "Lightheaded" if meals delayed
  - 49    Heart palpitates if meals missed or delayed
  - 50    Afternoon headaches
  - 51    Overeating sweets upsets

- 1 2 3**
- 52    Awaken after few hours sleep - hard to get back to sleep
  - 53    Crave candy or coffee in afternoons
  - 54    Moods of depression - "blues" or melancholy
  - 55    Abnormal craving for sweets or snacks
- GROUP 4**
- 56    Hands and feet go to sleep easily, numbness
  - 57    Sigh frequently, "air hunger"
  - 58    Aware of "breathing heavily"
  - 59    High altitude discomfort
  - 60    Opens windows in closed rooms
  - 61    Susceptible to colds and fevers
  - 62    Afternoon "yawner"
  - 63    Get "drowsy" often
  - 64    Swollen ankles, worse at night
  - 65    Muscle cramps, worse during exercise; get "charley horses"
  - 66    Shortness of breath on exertion
  - 67    Dull pain in chest or radiating into left arm, worse on exertion
  - 68    Bruise easily, "black and blue" spots
  - 69    Tendency to anemia
  - 70    "Nose bleeds" frequent
  - 71    Noises in head, or "ringing in ears"
  - 72    Tension under the breastbone, or feeling of "tightness", worse on exertion
- GROUP 5**
- 73    Dizziness
  - 74    Dry skin
  - 75    Burning feet
  - 76    Blurred vision
  - 77    Itching skin and feet
  - 78    Excessive falling hair
  - 79    Frequent skin rashes
  - 80    Bitter, metallic taste in mouth in mornings
  - 81    Bowel movements painful or difficult
  - 82    Worrier, feels insecure
  - 83    Feeling queasy; headache over eyes
  - 84    Greasy foods upset
  - 85    Stools light colored
  - 86    Skin peels on foot soles
  - 87    Pain between shoulder blades
  - 88    Use laxatives
  - 89    Stools alternate from soft to watery
  - 90    History of gallbladder attacks or gallstones
  - 91    Sneezing attacks
  - 92    Dreaming, nightmare type bad dreams
  - 93    Bad breath (halitosis)
  - 94    Milk products cause distress
  - 95    Sensitive to hot weather
  - 96    Burning or itching anus
  - 97    Crave sweets
- GROUP 6**
- 98    Loss of taste for meat
  - 99    Lower bowel gas several hours after eating
  - 100    Burning stomach sensations, eating relieves
  - 101    Coated tongue
  - 102    Pass large amounts of foul-smelling gas
  - 103    Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
  - 104    Mucous colitis or "irritable bowel"
  - 105    Gas shortly after eating
  - 106    Stomach "bloating" after eating

**1 2 3 GROUP 7A**

- 107    Insomnia
- 108    Nervousness
- 109    Can't gain weight
- 110    Intolerance to heat
- 111    Highly emotional
- 112    Flush easily
- 113    Night sweats
- 114    Thin, moist skin
- 115    Inward trembling
- 116    Heart palpitates
- 117    Increased appetite without weight gain
- 118    Pulse fast at rest
- 119    Eyelids and face twitch
- 120    Irritable and restless
- 121    Can't work under pressure

**GROUP 7B**

- 122    Increase in weight
- 123    Decrease in appetite
- 124    Fatigue easily
- 125    Ringing in ears
- 126    Sleepy during day
- 127    Sensitive to cold
- 128    Dry or scaly skin
- 129    Constipation
- 130    Mental sluggishness
- 131    Hair coarse, falls out
- 132    Headaches upon arising, wear off during day
- 133    Slow pulse, below 65
- 134    Frequency of urination
- 135    Impaired hearing
- 136    Reduced initiative

**GROUP 7C**

- 137    Failing memory
- 138    Low blood pressure
- 139    Increased sex drive
- 140    Headaches, "splitting or rending" type
- 141    Decreased sugar tolerance

**GROUP 7D**

- 142    Abnormal thirst
- 143    Bloating of abdomen
- 144    Weight gain around hips or waist
- 145    Sex drive reduced or lacking
- 146    Tendency to ulcers, colitis
- 147    Increased sugar tolerance
- 148    Women: menstrual disorders
- 149    Young girls: lack of menstrual function

**GROUP 7E**

- 150    Dizziness
- 151    Headaches
- 152    Hot flashes
- 153    Increased blood pressure
- 154    Hair growth on face or body (female)
- 155    Sugar in urine (not diabetes)
- 156    Masculine tendencies (female)

**GROUP 7F**

- 157    Weakness, dizziness
- 158    Chronic fatigue
- 159    Low blood pressure
- 160    Nails weak, ridged
- 161    Tendency to hives
- 162    Arthritic tendencies
- 163    Perspiration increase
- 164    Bowel disorders
- 165    Poor circulation
- 166    Swollen ankles
- 167    Crave salt
- 168    Brown spots or bronzing of skin
- 169    Allergies - tendency to asthma

**1 2 3**

- 170    Weakness after colds, influenza
- 171    Exhaustion - muscular and nervous
- 172    Respiratory disorders

**GROUP 8**

- 173    Apprehension
- 174    Irritability
- 175    Morbid fears
- 176    Never seems to get well
- 177    Forgetfulness
- 178    Indigestion
- 179    Poor appetite
- 180    Craving for sweets
- 181    Muscular soreness
- 182    Depression; feelings of dread
- 183    Noise sensitivity
- 184    Acoustic hallucinations
- 185    Tendency to cry without reason
- 186    Hair is coarse and/or thinning
- 187    Weakness
- 188    Fatigue
- 189    Skin sensitive to touch
- 190    Tendency toward hives
- 191    Nervousness
- 192    Headache
- 193    Insomnia
- 194    Anxiety
- 195    Anorexia
- 196    Inability to concentrate; confusion
- 197    Frequent stuffy nose; sinus infections
- 198    Allergy to some foods
- 199    Loose joints

**FEMALE ONLY**

- 200    Very easily fatigued
- 201    Premenstrual tension
- 202    Painful menses
- 203    Depressed feelings before menstruation
- 204    Menstruation excessive and prolonged
- 205    Painful breasts
- 206    Menstruate too frequently
- 207    Vaginal discharge
- 208    Hysterectomy / ovaries removed
- 209    Menopausal hot flashes
- 210    Menses scanty or missed
- 211    Acne, worse at menses
- 212    Depression of long standing

**MALE ONLY**

- 213    Prostate trouble
- 214    Urination difficult or dribbling
- 215    Night urination frequent
- 216    Depression
- 217    Pain on inside of legs or heels
- 218    Feeling of incomplete bowel evacuation
- 219    Lack of energy
- 220    Migrating aches and pains
- 221    Tire too easily
- 222    Avoids activity
- 223    Leg nervousness at night
- 224    Diminished sex drive

List the five main complaints you have in the order of their importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

# Daily Record of Food & Fluid Intake

NAME: \_\_\_\_\_

Each day, record *all* the items you eat and drink. (We are looking for 3 *typical* days)  
 Include the approximate amount & time of each item.

**Please bring this form to your nutritional evaluation appointment.**

**(1) Day: \_\_\_\_\_ Date: \_\_\_\_\_**

BREAKFAST (TIME: _____ )	LUNCH (TIME: _____ )	DINNER (TIME: _____ )
MID-MORNING SNACK (TIME: _____ )	MID-DAY SNACK (TIME: _____ )	NIGHT TIME SNACK (TIME: _____ )
-----		
Total Water Intake: _____ oz.	Other Fluid Intake: _____ oz.	Number of Bowel Movements: _____
Bedtime: _____ Hours of Sleep: _____	Quality of Sleep: (poor) 1 2 3 4 5 (good)	Overall Energy today: (1-10 scale): _____

**(2) Day: \_\_\_\_\_ Date: \_\_\_\_\_**

BREAKFAST (TIME: _____ )	LUNCH (TIME: _____ )	DINNER (TIME: _____ )
MID-MORNING SNACK (TIME: _____ )	MID-DAY SNACK (TIME: _____ )	NIGHT TIME SNACK (TIME: _____ )
-----		
Total Water Intake: _____ oz.	Other Fluid Intake: _____ oz.	Number of Bowel Movements: _____
Bedtime: _____ Hours of Sleep: _____	Quality of Sleep: (poor) 1 2 3 4 5 (good)	Overall Energy today: (1-10 scale): _____

**(3) Day: \_\_\_\_\_ Date: \_\_\_\_\_**

BREAKFAST (TIME: _____ )	LUNCH (TIME: _____ )	DINNER (TIME: _____ )
MID-MORNING SNACK (TIME: _____ )	MID-DAY SNACK (TIME: _____ )	NIGHT TIME SNACK (TIME: _____ )
-----		
Total Water Intake: _____ oz.	Other Fluid Intake: _____ oz.	Number of Bowel Movements: _____
Bedtime: _____ Hours of Sleep: _____	Quality of Sleep: (poor) 1 2 3 4 5 (good)	Overall Energy today: (1-10 scale): _____