The Bridge to Health
Client Information

In advance of your upcoming appointment with The Bridge to Health, please complete the following questionnaire. It is important to begin with a thorough history in order to provide the best possible care. By completing this questionnaire, we will save valuable time during your appointment and allow us to focus on attaining your health goals.

You should plan for about 60-90 minutes for your initial visit. There is much information we want to share with you, and we want to allow ample time to answer questions. **If you need to reschedule your visit, please call so we can keep the time open for others.**

We're looking forward to your visit.

Appointment Desk: (920) 965-7719

How did you hear about us?

_____ yellow pages

_____ newspaper/magazine article

_____ newspaper/magazine advertizing

_____ website

_____ health fair/expo

_____ public presentation/class

_____ physician (who) _________________________

_____ other health care provider (who) _______________________

_____ friend

_____ other (please specify) _________________________________

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CONTACT INFORMATION :

Name ___________________________

Address ____

Phone Number (home) ________________________(work) ____________________________(cell) ____________________

Email _______________________________________ What's the best way to reach you? ________________________

Date of Birth ____

Who is your Primary Care Provider?
Name: _______________________________________
Address or city: _______________________________

Health Issue

Reason for your visit (Describe heath concerns, duration, events surrounding, expectations/hopes)

What symptoms do you experience?

Specific diagnosis if applicable

General concerns (other things you wonder about)

What is your image of your health status at the present time? How does this compare to the past?

Medications

Please bring all medications (including herbals and supplements) with you at time of visit

List current medications:

Name dose frequency why do you take this?

____
____
____
____
____
____
____
____
____
____
____
____

Over the counter medications you use including vitamin, supplements and herbal remedies:

Name dose frequency why do you take this?

____
____
____
____
____
____
____
____
____

Allergies: ____

What kind of reaction did you have? ____

Are there any medicines you don't tolerate? Please list: ______________________________

Past medical and surgical history:

Please circle any past or current symptoms or illnesses. Please provide details on back of page:

High Blood Pressure Heart Problems Heart Attack Heart rhythm abnormalities Palpitations
Angina/chest pain Congestive Heart Failure Heart Murmur Stroke Fainting spells Depression
Anxiety Panic Attacks Bipolar Fibromyalgia TMJ Asthma Allergies Sinus Problems
Frequent Colds Bronchitis Lung Problems Chronic Cough Difficulty Breathing Emphysema
Dizziness or Vertigo Insomnia Restless Legs Liver Disease Hepatitis Kidney problems Bladder problems
Anemia Glaucoma Stomach problems Ulcers GERD Abdominal Pain Head or neck injury
Loss of Consciousness Seizures Thyroid problems Diabetes AIDS Mononucleosis Migraine
Headaches Cancer Multiple Sclerosis Irritable Bowel Syndrome (IBS) sexually transmitted disease
Arthritis Pain issues (Describe if not previously noted) Other (describe)

Men: difficulty with erection or maintaining erection prostate problems

Women: When was your last period? ________ How long does it last? _______ Regular cycle? _____
Number of pregnancies? _______ Number of Births ____________ Sexual Difficulties ______

Have you ever needed to be hospitalized over night or had surgery?

Hospitalization Reason or Surgery	Date/Year	Name of Hospital

Have you ever been treated in the Emergency Department? _____ Describe:

What is your tendency toward illness (are you sick often, do you recover quickly?)

What is your weight? _______lbs. What was your weight a year ago?_________ What is your height? __________
Do you wear glasses or contacts _________ Do you get regular eye exams? _____
Describe any visual disturbances (blurred, double vision, brief loss of vision, etc.)

Have you ever had blood transfusion? ______ Have you received your Hepatitis B vaccines? _______
Have you ever had a blood test for AIDS or Hepatitis ______ Do you have reason to believe you may have been exposed to any of these viruses?__________

Personal History

Marital status: Single Married Widowed Divorced Other______________
Smoking history: None Cigarettes Cigars Pipe
How many per day?____________________
How many years?______________________
If you have quit, When did you quit?____________what was your past smoking history?_______
How often do you consume alcohol? Daily____ times per week____times per month____times per year______Never ______
Recreational Drugs? When______________ What_____________________

Sleep: How many hours do you usually sleep per night?_______ Do you routinely sleep this amount?________
Do you have difficulty fa1ling asleep?________ Do you have difficulty staying asleep?_________ Do you feel rested upon rising?__________________ Are you a restless sleeper _______Have you been told you snore?________

What's your energy level like? (Do you have the energy to do all the things you want?)

Diet: Number of meals per day ______ number of snacks _______ What's your appetite like? _____________
_______number of fruits and vegetables per day _______servings of calcium per day

_______servings of caffeine per day ____________servings of water per day
Selections (most common foods you eat), any special relationship to foods?

What do you do for exercise?

How Often do you exercise?

What do you do for relaxation?

What do you do for fun?

Is it still fun? _______

Other than yourself, who lives in your house? (include names and ages)

Describe your relationships with others: (quality of relationship, activities together, level of support, etc)
Parents:

Siblings:

Spouse/Significant other:

Children:

Friends:

Do you have a history of abuse (emotional, physical, sexual)?

If you are currently in a relationship, do you feel safe?

Describe any pivotal or traumatic events in your life:

What is your educational background?

What type of work do you do?

Do you enjoy your work?

Do you work different shifts? ____ Describe the work environment:

Coworkers: (relationships, support)

Describe any stressors you are experiencing with your job

Sources of stress (work and personal life):

Coping practices (how do you deal with stressors?):

Who do you go to for support? (someone you can confide in, someone to count on for help, etc)

Describe your typical day:

How would you describe your self? (happy, caring, sad, friendly, a perfectionist, a worrier, etc)

How do you think others see you?

What gives you strength? (Spirituality/belief system, family, etc)

What joys and/or fears do you have?

What do you do well?

What are your hopes for the future?

Family Medical History

Please include information about your mother, father, sister(s), brother(s), children, aunt(s), uncle(s),
And grandparents such as **headaches, strokes, seizures, as well as heart disease, diabetes, cancer, hypertension, alcoholism, depression, or suicide.**

Father:

Mother:

Brothers(s):

Sisters(s):

Children:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Paternal aunts and uncles:

Maternal aunts and uncles:

Grandchildren:

Have you experienced any of the following events in the past year?
____Death of spouse
____Divorce
____Marital Separation
____Jail term
____Death of a close family member
____Personal injury or illness
____Marriage
____Loss of a job through firing
____Marital reconciliation
____Retirement

Any additional comments: