NEW CLIENT EVALUATION

Optimal Living Institute

Please print clearly:

Name_____ Date _____

Address _____ Apt.# _____

City _____ State _____ Zip _____

Mailing Address (if different) _____

_____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Work Phone (_____) _____-_____

E-mail address: _____

REFERRED BY: _____

Date of Birth _____Age _____ Sex: M / F

Occupation _____ Employer _____

Marital Status: Married Single Widowed Divorced Name of Spouse: _____

Names and Ages of Children: _____

Emergency Contact:_____

Chief Compaint--*Please tell us the main reason why you are here*: _____

_____

_____

_____

Secondary Complaints--*Please let us know any other health concerns that you have*: _____

_____

_____

_____

Previous Treatment for these Complaints: _____

_____

_____

_____

Major Illness--*Please list any major illnesses and approximate dates*: _____

_____

_____

Injuries—*Please list any accidents or injuries, and approximate dates*: _____

_____

_____

NEW CLIENT EVALUATION

Optimal Living Institute

Primary Care Doctor	Office Number	Last Physical Exam
Height Weight	*For Weight Loss Patients:* *Goal Weight*	Lowest Adult Weight
Main Reason for Visit		REFERRED BY

MEDICAL & FAMILY HISTORY	Self	Family		Self	Family		Self	Family
Seizures			Asthma			Diarrhea		
Migraines or Headaches			Sleep Apnea			Liver Disease		
Dizziness			Pulmonary Hypertension			Gallbladder disease/stones		
Loss of Consciousness			Pulmonary Hypertension			Ulcers		
Stroke			Shortness or Breath			Colitis		
Glaucoma			Irregular heart rhythm			Constipation		
Thyroid Disorder			Heart Attack or Angina			Arthritis		
Obesity/Overweight			Palpitations			Gout		
Diabetes Mellitus (DM)			Heart Valve disorder			Osteopenia or Osteoporosis		
High Blood Sugar			Heart Failure (CHF)			Kidney Disease or stones		
Abnormal Cholesterol			High Blood Pressure			Alcohol Abuse		
Insomnia			Rheumatic Fever			Drug Abuse		
Dementia			Tuberculosis			Depression or Anxiety		
			HIV			Eating Disorder		
Other			Cancer type:			Other Psychiatric Illness		

DOCTOR NOTES:

SURGERIES & HOSPITILIZATIONS

Reason/Diagnosis	Year

SPECIALISTS (If any)

PRESCRIPTION MEDICATIONS

Medication Name	Dose & Frequency	Approx. Start Date	Reason for use

SUPPLEMENTS & OVER-THE-COUNTER MEDICATIONS

Supplement/Medication Name	Dose & Frequency	Approx. Start Date	Reason for Use

SCREENING

Test	Last date done	Results (-) *or state findings*
Blood Sugar, Cholesterol		
Colonoscopy		
PAP Smear (women)		
Mammogram (women)		
Prostate exam (men)		
Cardiac test (EKG, echo, stress, etc)		
Transvaginal Ultrasound		

FEMALE patients: Please check all that apply

	NONE	MILD	MODERATE	SEVERE
Anxiety/nervousness				
Concentration loss				
Depression/emotional swings				
Dry skin/wrinkles				
Dry hair				
Fatigue				
Food cravings				
Hair loss				
Hot flashes				
Irritability				
Loss of libido/orgasm				
Loss of pubic hair				
Memory loss				
Muscle weakness/loss				
Muscle and joint pain				
Night sweats				
Sleep disorder				
Urine Leakage				
Vaginal Dryness				

MALE patients: Please check all that apply

	NONE	MILD	MODERATE	SEVERE
Anxiety/nervousness				
Concentration loss				
Depression				
Difficulty maintaining erection				
Difficulty achieving erection				
Dry Hair				
Dry Skin				
Fatigue				
Irritability				
Loss of masculinity/confidence/aggressiveness				
Loss of libido/orgasm				
Memory loss				
Muscle weakness				
Muscle loss				
Muscle and joint pain				
Premature ejaculation				
Sleep disorder				

FEMALE PATIENTS: OB/GYN History

Last Menstrual Period: Age at first onset of period:
If still menstruating: cycle _____days Circle if (+): Heavy periods, irregularity, spotting or pain
Are you pregnant: NO YES Are you breastfeeding: NO YES
Number of pregnancies: C-section/Vaginal Birth Abortions_____ Miscarriages_____
History of sexual abuse

PERSONAL AND SOCIAL HISTORY

Occupation: Stress Level (1-10):
Marital Status: Do you feel safe in your relationship: # Living Children:
Use of alcohol **NO** **YES** If YES, what kind: How many drinks per week:
Tobacco: **NO** **YES** If YES, number of years total _____ Past-use---quit date: _____
Recreational or street drug use: **NO** **YES** If YES, have you ever taken street drugs with a needle: NO YES
Sexually active **NO** **YES** *Contraception* Current method:_____ Past method: _____
Hobbies/Interests

REVIEW OF SYSTEMS: *Please check YES to any symptom that you experience and describe.*

	YES	If YES, **list doctor seen**, describe condition and how long
Fever/chills		
Excess fatigue		
Weight loss/gain		
Enlarged lymph nodes		
Frequent bruising		
Blurry vision		
Ringing in ears		
Hearing difficulty		
Mouth sores		
Sinus problems		
Cardiovascular:		
Cold hands/cold feet		
Chest pain at rest or exercise		
Swelling of legs		

GASTROINTESTINAL: Please check YES to any symptom you experience and describe

	YES	
Constipation		# bowel movement/day
Diarrhea		
Bloating		
Excessive belching		
Gas/acidity		
Blood in stool		
Thirst: Lack of/too much		# glasses of fluid/day

GENITOURINARY: Please check YES to any symptom you experience and describe

Pain on urination	YES	
Cloudy/blood urination		
Urinating too many times		# of time per day
Difficulty urinating		
Loss of Urine		

MUSCULOSKELETAL: If YES to any of the following questions, please grade pain 1-10.

	YES	
Did you see a chiropractor?		
Any regular body treatment/massage?		
Back Pain		
Neck Pain		
Shoulder Pain		
Arm Pain		
Hip Pain		
Knee Pain		
Other Pain		
Muscle point tenderness (please describe)		

SKIN: If YES to any of the following questions, please describe.

	YES	
Acne		
Dry Skin		
Oily Skin		
Loss of collagen/Firmness		
Wrinkles		
Pigmentation/Scarring		
History of skin cancer?		
Do you wear sunblock?		

EMOTIONAL: If YES to any of these questions, please describe.

	YES	
Do you see a counselor or psychiatrist?		
Depression		
Anxiety		
Stress		
Previous or current thoughts of suicide?		

I have answered the above questions to the best of my abilities.

Patient Signature _____ Date _____

NUTRITION EVALUATION

Vegetable intake (please circle): <10% 20-40% 41-60% >60%
Number of meals per day:
Snacks per day: What snacks and when?
Food Allergies
Food Dislikes
Foods(s) you crave
Do you awaken hungry during the night? If yes, when?
Behavior style (*check only one:)* ____Always calm and easygoing ____Usually calm and easygoing ____Sometimes calm with frequent impatience ____Seldom calm and persistently driving for advancement ____Never calm and have overwhelming ambition ____Hard-driving and can never relax

	NO	YES		NO	YES	If not you, WHOM?
Partner or spouse overweight?			I plan my meals			
By how much? lbs			I cook my meals			
I eat out daily			I shop for food.			
I eat out _____times/week			I use shopping list for grocery			
I eat “fast foods” daily			I eat “fast foods”____ times/week			
I use sugar substitute			I use butter.			
I drink soda drinks.			I use margarine.			
I eat when I’m stressed.			I drink coffee or tea. How many cups?			
I am currently stressed.			I skip meals.			

Typical Breakfast	Typical Lunch	Typical Dinner
Time:	Time:	Time:
Where:	Where:	Where:
With whom?	With whom?	With whom?

ACTIVITY LEVEL (check only one):

_____ Inactive: no regular physical activity with a sit-down job.
_____ Light activity: no organized physical activity during leisure time.
_____ Moderate activity: occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
_____ Vigorous activity: participation in extensive physical exercise for at least 60 minutes per session at least 4 times per week.

Please describe your general health goals and improvements you wish to make:

Patient Signature: _____ **Date:** _____

Additional DOCTOR notes: