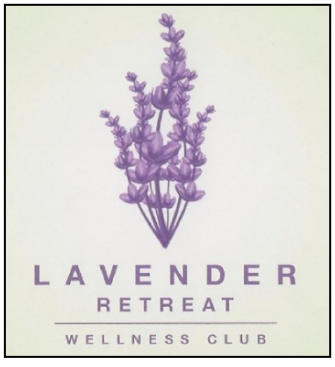

Welcome to Lavender Retreat Wellness Club

1236 Pennsylvania Ave SE, Washington DC, 20003
www.lavender-retreat.com Tel: 202.450.2329

Nutrition

All written records are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client (you) or the client's legal guardian — unless legally required by local, state or federal subpoena, summons, or other court order.

New Patient Questionnaire

Please allow 30-45 minutes to complete most of this questionnaire. The 3-day diet diary will require you to record your food and beverage intake over a 3-day period. Please answer the questions below as thoroughly as possible so that we may make the best possible clinical assessment. This helps us develop a realistic and workable plan for supporting you in reaching your health goals. Your answers to personal questions such as relationship status, religion, etc. are important as they provide helpful context for establishing a productive partnership with you. That said; please answer only the questions you are comfortable answering.

Please print clearly Today's Date: _____

Name (First)_____ (Last) _____

Address _____**City**_____ **State** _____ **Zip** _____

Social Security # _____ Gender ☐ Male ☐ Female **Date of Birth**: _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated **Spouse Name** _____
Language preference: ☐ English ☐ Spanish ☐ Other:_____ **Ethnicity** (Italian, Polish, etc.):_____

Race ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Middle-Eastern ☐ Pacific Islander ☐ Native American

Home Phone# _____ Work/Cell Phone# (please circle one) _____

Email Address: _____ **Contact Preference** (email, cell etc.) _____

How were you referred to our office? _____

Your Occupation _____Employer_____

Address _____

City _____ State _____ Zip _____

Primary Care Provider: Do you have a primary care physician? ☐Yes ☐No

Doctor's name: _____ Office Address: _____

Phone #: _____ Fax #: _____

PHYSICAL MEDICINE

DO YOU HAVE A PACEMAKER: ☐ Yes ☐ No

Medications

Date Started	Medication	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements/Vitamins

Date Started	Supplement/Vitamin	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medication

Medicine	Reaction
_____	_____
_____	_____

Hospitalizations

Date	Reason
_____	_____
_____	_____

What health concerns did you experience as a child?

What health concerns have you experienced as an adult?

Has your doctor diagnosed you with a medical condition (s)? ____ If so, please list:

Are you part of a recovery program? ____ If so, which one?

Do you have any allergies to foods, medications, chemicals, and/or other environmental substances? If so, to which ones?

What is your typical reaction and how severe is it (1-10)?

What, if any, surgeries/operations have you undergone, and when?

Have you ever had a major chemical exposure? ____ If so, when and to what?

Where and when have you lived or traveled outside of the U.S. and Canada?

Is there anything that surfaced during a recent medical test, lab work, or doctor's visit that you would like to report?

Family History

Relationship	Alive/Deceased	Present Health or Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Mother		
Father		
Brothers		
Sisters		
Children/ages		

For Women

Pregnancies (please include losses/terminations)			
Year	Vaginal/C Section	Sex	Complications/ Other things you want to mention

Are you currently pregnant? ____ Are you actively trying to conceive? ____ Are you breastfeeding? ____

For Everyone

Physical Activity					
	Frequency				
	Monthly	Weekly	Daily	Multiple times a day	Comments
Active Lifestyle					
Cardio Type Exercise					

Strength Building Exercise					
Stretching					
How would you categorize your activity level?	_____ Sedentary _____ Mildly Active _____ Moderately Active _____ Very Active _____ Intensely Active				

Sleep	
What time are you typically in bed?	
What time do you fall asleep?	
Typical hours of sleep?	
# of times you awaken during the night?	
Reason(s) you wake during the night?	
Do you feel rested upon rising?	

Lifestyle					
	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Sexual Activity					
Socializing with Friends					
Relaxation/ Self Pampering					What type(s)?
Tobacco					What type(s)?
Recreational Drugs					What type(s)?
Teeth Flossing					

Significant Life Events
Please list major events in the last ten years of your life and the dates they occurred. Include illness, medical condition, births, deaths, marriage, divorce, accidents, moves, jobs changes, miscarriages, and anything else you feel greatly impacted your life.
Date Event

Stress							
On a scale of 1-10, 1 being low and 10 being high, how stressful is your:							
Work:		Social/Family Situation:		Current Health Status:		Life in general:	
Do you feel your current state of health is:		_____ Largely in your control		_____ Largely out of your control			
What do you believe you could do to make a difference in your current health status?							
If so, what 1-2 key steps have you already taken?							

Have you ever had or current have any of the following conditions?

Gastrointestinal
- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ Gastritis or Peptic Ulcer Disease
- ☐ GERD (reflux)
- ☐ Celiac Disease
- ☐ Other _____

Cardiovascular
- ☐ Heart Attack
- ☐ Stroke
- ☐ Elevated Cholesterol
- ☐ Hypertension (high blood pressure)
- ☐ Other _____

Metabolic/Endocrine
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Hypoglycemia
- ☐ Metabolic Syndrome
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Endocrine Problems
- ☐ Infertility
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Frequent Weight Fluctuations
- ☐ Bulimia
- ☐ Anorexia
- ☐ Eating Disorder (non-specific)
- ☐ Other _____

Cancer
- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Other _____

Genital and Urinary Systems
- ☐ Kidney Stones
- ☐ Gout
- ☐ Frequent Yeast Infections
- ☐ Erectile or Sexual Dysfunction

Musculoskeletal/Pain
- ☐ Osteoporosis/Osteopenia
- ☐ Scoliosis
- ☐ Muscle Pain
- ☐ Arm Numb/Tingling
- ☐ Leg Numb/Tingling
- ☐ Neck Pain
- ☐ Middle Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Elbow Pain
- ☐ Hand/Wrist Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Ankle/Foot Pain
- ☐ Joint Pain _____
- ☐ Other _____

Inflammatory/Autoimmune
- ☐ Chronic Fatigue Syndrome
- ☐ Autoimmune Disease
- ☐ Rheumatoid Arthritis
- ☐ Lupus SLE
- ☐ Immune Deficiency Disease
- ☐ Poor Immune Function (Frequent Infections)
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Multiple Chemical Sensitivities
- ☐ Latex Allergy
- ☐ Other _____

Respiratory Diseases
- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Other _____

Skin Diseases
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Melanoma
- ☐ Skin Cancer: Type _____

Neurologic/Mood
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Headaches
- ☐ Migraines
- ☐ ADD/ADHD
- ☐ Memory Problems
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Other Neurological Problems _____

Preventative Tests and Date of Last Test

☐ Full Physical Exam _____
☐ Bone Density _____
☐ Colonoscopy _____
☐ Cardiac Stress Test _____
☐ EBT Heart Scan _____
☐ EKG _____
☐ Hemoccult Test-stool test for blood _____
☐ MRI _____
☐ CT Scan _____
☐ Upper Endoscopy _____
☐ Upper GI Series _____
☐ Ultrasound _____

Surgeries

☐ Appendectomy _____
☐ Hysterectomy _____
☐ Gall Bladder _____
☐ Hernia _____
☐ Tonsillectomy _____
☐ Dental Surgery _____
☐ Joint Replacement Knee/Hip _____
☐ Heart Surgery – Bypass Valve _____
☐ Angioplasty or Stent _____
☐ Pacemaker _____
☐ Other _____
☐ None