SHAKTHI
HEALTH & WELLNESS CENTER
Optimize YOUR Vitality
a dhruvacare enterprise

2702 Back Acre Circle, Suite 190
Mount Airy, MD 21771
Phone: 301-703-5067
Fax: 301-703-8880
Email: info@raowellness.com

Name (Last, First, Mi)		Date of Birth
Gender	Marital Status M S D	Home Phone
Address		Cell Phone
		Work Phone
Email Address		Preferred Method of Contact
Emergency Contact Name		Emergency Contact Phone
Primary Care Physician's Name		Physician's Phone
Preferred Pharmacy		Pharmacy Phone

History

Reason for consultation: _____

_____

Health Concerns/Symptoms: _____

_____

Are you currently under the care of a healthcare professional for a medical/health condition: ___ No ___ Yes

If yes, please describe condition(s):

_____

_____

Patient Name: _____ Date: _____

Please list all PRESCRIPTION medications you currently take on a regular basis

NAME OF MEDICATION	DOSE (mg, ml, IU, etc.)	DATE STARTED

Please list all VITAMINS/MINERALS, HERBS or OTHER SUPPLEMENTS you currently take on a regular basis

NAME AND BRAND OF SUPPLEMENT	DOSE (mg, ml, IU, etc.)	DATE STARTED

Please list any Medication and/or Environmental/Food Allergies you may have:

ALLERGEN	REACTION

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Office Hours
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Saturday Closed
Sunday Closed

Patient Name: _____ Date: _____

MEDICATIONS & SUPPLEMENTS

- Have you had prolonged or regular use of NSAIDs (Advil, Aleve, Motrin, Aspirin, etc.) ?

  _____

- Have you had prolonged or regular use of antibiotics?

  _____

- Have you had prolonged or regular use of steroids (prednisone, nasal allergy inhalers, etc.)?

  _____

TESTS & PREOCEDURES

TEST/PROCEDURE	DATE OF MOST RECENT EXAM	RESULT: NORMAL OR ABNORMAL
Bone Density Scan		
Mammogram		
Breast exam using Thermography		
Colonoscopy		
Skin Exam		
Cardiac Stress Test		
Calcium Coronary Scan/Test		
Carotid Artery Ultrasound		
Glaucoma Test		
Uterine Ultrasound		
Pap Smear		
Any additional tests/procedures:		

Patient Name: _____ Date: _____

MEDICAL HISTORY

RESPIRATORY			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Asthma			
Chronic Bronchitis			
Emphysema (COPD)			
Pulmonary Hypertension			
Chronic Sinusitis			
Pneumonia			
Sleep Apnea			
Tuberculosis			

BLOOD PRESSURE			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
High Blood Pressure			
Low Blood Pressure			

BLEEDING			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Blood Clots			
Hemophilia			
Factor V Leiden			

CARDIOVASCULAR			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Coronary Artery Disease			
Heart Attack			
Congestive Heart Failure			
Coronary Artery Blockage			
Carotid Artery Stenosis			
Arrhythmia			

CHOLESTEROL			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
High Cholesterol			
High Triglycerides			

GASTROINTESTINAL			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Reflux (heatburn)			
Stomach Ulcers			
Gall Bladder Disease			

Patient Name: _____ Date: _____

Liver Disease			
Inflammatory Bowel Disease			
Crohn's Disease			
Ulcerative Colitis			
Celiac Disease			

BLOOD SUGAR			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Elevated Blood Sugar (pre-diabetic)			
Diabetes (onset in youth – treated with insulin)			
Diabetes (onset as adult – treated with diet)			
Diabetes (onset as adult – treated with medication)			

WEIGHT			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Obesity			
Overweight			
Underweight			
Anorexia			
Bulimia			

THYROID			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Low Thyroid (hypothyroidism)			
Hashimoto's Thyroiditis			
High Thyroid (hyperthyroidism)			
Thyroid Nodules			
Graves Disease			
Goiter			

NEUROLOGICAL			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Stroke			
Migraines			
Seizures			
ADD/ADHD			
Brain Injury/Concussion			

HISTORY OF MENTAL ILLNESS			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Depression			
History of Suicide Attempts			
Anger Management Problem			

Patient Name: _____ Date: _____

Bipolar Disorder			
Post-Traumatic Stress Disorder			

JOINT AND BONE			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Arthritis			
Rheumatoid Arthritis			
Gout			
Osteopenia (weakening bones)			
Osteoporosis (weak bones)			

IMMUNE SYSTEM			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
HIV			
Hepatitis			
Herpes			
Mononucleosis (EBV)			
Epstein-Barr Virus			
Multiple Sclerosis			
Lupus SLE			

ENERGY PROBLEM			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Chronic Fatigue Syndrome			
Fibromyalgia			

CANCER HISTORY			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Breast Cancer			
Uterine Cancer			
Cervical Cancer			
Colon Cancer			
Ovarian Cancer			
Skin Cancer			
Lung Cancer			
Bladder Cancer			
Kidney Cancer			
Thyroid Cancer			
Pancreatic Cancer			
Lymphoma Cancer			
Leukemia Cancer			
Others:			

Patient Name: _____ Date: _____

SKIN			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Eczema			
Hives			
Athlete's Foot			
Psoriasis			
Acne			
Vitiligo			

GYNECOLOGICAL HISTORY			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
Have you ever been diagnosed with ovarian cysts?			
Have you ever been diagnosed with endometriosis?			
Have you ever been diagnosed with uterine fibroids?			
Have you ever been diagnosed with polycystic ovarian syndrome? (PCOS)			
Have you ever been diagnosed with fibrocystic breast disease?			
Have you ever had PMS?			
Have you ever used birth control pills?			
Have you stopped having periods?			
Do you have a history of infertility?			

OBSTETRIC HISTORY			
Have you ever experienced any of the following?	**YES**	**NO**	**DON'T KNOW**
How many times have you been pregnant?			
Have you ever experienced postpartum depression?			
Have you ever had gestational diabetes?			

SURGERY & HOSPITAL

SURGERY			
Have you had any of the following surgeries?	**YES**	**YEAR OF SURGERY**	**NO**
Breast Lump Removal (Lumpectomy)			
Breast One Removed (Unilateral Mastectomy)			
Breasts Both Removed (Bilateral Mastectomy)			
Breast Enlargement (Breast Augmentation)			
Breast Reduction			
Cataract Surgery			
Coronary Artery Blockage (Angioplasty)			
Open Heart Surgery (Coronary Bypass)			
Tonsils Removed (Tonsillectomy)			
Thyroid Removed			
Gall Bladder Removed (Cholecystectomy)			
Uterus Removed			

Patient Name: _____ Date: _____

Fibroid of the Uterus Removed			
Cesarean Section			
D & C (Dilation and Curettage)			
Tubes Tied (Tubal Ligation)			
Ovary One Removed			
Ovaries Both Removed			
Hip Replacement			
Low Back Surgery			
Colon Removed (Colostomy)			
Hernia Repair			
Hemorrhoid Surgery			
Appendix Removed (Appendectomy)			
Other:			

HOSPITALIZATIONS			
Have you been hospitalized for any of the following?	**YES**	**YEAR OF HOSPITAL VISIT**	**NO**
Pregnancy			
Congestive Heart Failure			
Chest Pain			
Hardening of the Arteries (Coronary Atherosclerosis)			
Heart Attack			
Chronic Obstructive Lung Disease			
Stroke (Acute Cerebrovascular Disease)			
Irregular Heartbeat (Cardiac Dysrhythmias)			
Mood Disorders (depression and bipolar depression)			
Dehydration			
Urinary Infections			
Asthma			
Diabetes			
Skin Infections			
Infection of Blood Stream (Sepsis)			
Gallbladder Disease			
Gastrointestinal Bleeding			
Hip Fracture			
Appendicitis			
Other:			

Patient Name: _____ Date: _____

SOCIAL HISTORY

	CIRCLE THE CORRECT CHOICE BELOW		
Use Tobacco	**YES**	**NO**	**QUIT**
Use Alcohol	**YES**	**NO**	**IN RECOVERY**
Other Substances	**YES**	**NO**	
Do you have a history of using recreational or street drugs?	**YES**	**NO**	
Do you currently use recreational or street drugs?	**YES**	**NO**	
Do you have any children?	**YES**	**NO**	

IMMUNIZATIONS			
Have you had the following immunizations?	**YES**	**NO**	**DON'T KNOW**
Chickenpox			
Measles			
Hepatitis			
HPV			
Shingles			
Whooping Cough			
Tetanus			
Pneumonia			

FAMILY HISTORY/PAST MEDICAL HISTORY

	STATUS				
FAMILY MEMBER (BIOLOGICAL)	**LIVING**	**DECEASED**	**UNKNOWN**	**AGE**	**CAUSE OF DEATH**
Mother					
Father					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					

- Are you adopted? _____

Patient Name: _____ Date: _____

Please check any medical conditions or health problems that any family member may currently have or have had in the past:

CONDITION	NONE	MOTHER	FATHER	BROTHER	SISTER	GRAND MOTHER	GRAND FATHER	AUNT	UNCLE
Breast Cancer									
Ovarian Cancer									
Uterine Cancer									
Prostate Cancer									
Colon Cancer									
Heart Attack									
Heart Disease									
High cholesterol									
High Blood Pressure									
Diabetes & Type									
Stroke									
Obesity									
Thyroid Disease									
Kidney Disease									
Liver Disease									
Lung Disease									
Osteoporosis									
Alzheimer Dementia									
Depression									
Schizophrenia									
Bipolar Disorder									
Alcoholism									
Drug Abuse									
OTHER:									

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MSQ – Medical Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point scale:
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Frequently have it, effect is not severe
3 = Occasionally have it, effect is severe
4 = Frequently have it, effect is severe

Digestive Tract	___ Nausea or vomiting ___ Diarrhea ___ Constipation ___ Bloated feeling ___ Belching or passing gas ___ Heartburn Total: _____	Lungs	___ Chest congestion ___ Asthma, bronchitis ___ Shortness of breath ___ Difficulty breathing Total: _____
Ears	___ Itchy ears ___ Ear aches, ear infections ___ Drainage from ears ___ Ringing in ears, hearing loss Total: _____	Mind	___ Poor memory ___ Confusion, poor comprehension ___ Difficulty in making decisions ___ Stuttering or stammering ___ Slurred speech ___ Learning disabilities Total: _____
Emotions	___ Mood swings ___ Anxiety, fear or nervousness ___ Anger, irritability or aggressiveness ___ Depression Total: _____	Mouth/ Throat	___ Chronic coughing ___ Gagging frequently; need to clear throat ___ Sore throat, hoarseness, loss of voice ___ Swollen or discolored tongue, gums, lips ___ Canker sores Total: _____
Energy & Activity	___ Fatigue, sluggishness ___ Apathy, lethargy ___ Hyperactivity ___ Restlessness Total: _____	Nose	___ Stuffy nose ___ Sinus problems ___ Sneezing attacks ___ Excessive mucus formation Total: _____
Eyes	___ Watery or itchy eyes ___ Swollen, reddened or sticky eyelids ___ Bags or dark circles under eyes ___ Blurred or tunnel vision (does not include near or far sightedness) Total: _____	Skin	___ Acne ___ Hives, rashes, or dry skin ___ Hair loss ___ Flushing or hot flashes ___ Excessive sweating Total: _____
Head	___ Headaches ___ Faintness ___ Dizziness ___ Insomnia Total: _____	Weight	___ Binge eating ___ Excessive weight ___ Water retention ___ Underweight Total: _____
Heart	___ Irregular or skipped heartbeat ___ Rapid or pounding heartbeat ___ Chest pain Total: _____	Other	___ Frequent illness ___ Frequent or urgent urination ___ Genital itch or discharge Total: _____
Joints & Muscles	___ Pain or aches in joints ___ Arthritis ___ Stiffness or limitation of movement ___ Pain or aches in muscles ___ Feeling of weakness or tiredness Total: _____		***Grand Total:*** _____

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