

LifeSource Wellness Care Patient Clinical Update

This document helps us find out what's new with you and your health.

Patient Name _____

My last meal was: **BREAKFAST LUNCH DINNER SNACK DRINK** @_____ AM/PM

Please give us your current HOME ADDRESS / HOME & CELL PHONE / E-MAIL Address:

Home Phone _____ Cell Phone _____ E-Mail _____

Home Address _____

The MAIN REASON FOR TODAY'S OFFICE VISIT:

What makes the problem:

Better? Worse? What doesn't work? For how long has this been happening?

Three other Health Concerns I would like to discuss today are:

1. _____
2. _____
3. _____

Additional concerns can be discussed at another appointment when we have time dedicated to that specific concern.

We are trying to get to the root of your Problem – please circle below any of these symptoms:

Constitutional Symptoms: Fever Chills Recurrent Infections Weight Loss / Gain Fatigue Malaise
Appetite +/- Depression Anxiety *History of HIV Epstein-Barr Virus LYME Disease Hepatitis
A / B / C / D Herpetic Infections Shingles Mouth Sores Genital / Other Sores

Skin Problems: Rash Sores Bug-Bites Eczema Psoriasis Contact Allergy

H-ENT:

Headache: Sinus / Tension / Migraine / Menstrual

History of Head Trauma: Loss of Consciousness / Fainting

Eye Pain: Discharge / Irritation / Blurred Vision

Ear Pain: Discharge / Tinnitus / Sensitivity

Nasal Discharge: Congestion / Post Nasal Drip / Bloody Nose

Trouble Swallowing: Sore Throat / Voice Changes / Neck Pain / Swollen Glands

Respiratory: Cough / Short of Breath / Wheezing / Chest Pain PND / Asthma / Smoker / Short of Breath when Sleeping

Blood / Blood Vessels: Easy Bruising, Excessive Bleeding, Painful Veins, Muscle Cramping, Leg Swelling

Heart: History of Heart Issues, Chest Pain, Short of Breath with Exertion, Palpitations, Irregular Beat, Fainting

Gastro-Intestinal: Abdominal Pain, Nausea / Vomiting, Diarrhea, Spitting Up Blood, Constipation, Passing Gas, Heartburn / GERD

Genito-Urinary: Increased Frequency of Urination / Burning Blood in Urine Penis / Vagina Problems / Discharge Incontinence

Neuro-Muscular: Neck/ Back Pain, Disc Issues, Arthritis, Joint Pain, Headaches, Numbness, Radiating Pain, Seizures

Stressors: Health, Work, Financial, Spouse / Partner, Parents, Kids, Anxiety, Mood Swings, Insomnia, Depression, Fatigue

Hormones: Hot Flashes, Night Sweats, Insomnia, Moody, Fatigued, Depressed, Memory Issues, Brain Fog, Low Libido, Heat / Cold Problems

Women: Breast Problems, Vaginal Dryness, Painful Intercourse, Vaginal Discharge, Breast Tenderness, Climax Problems

Men: Penis/ Erection Issues, Discharge, Testicle Pain, Testicle Lump

Breast Issues: History of Breasts Implants, New Lump, Swelling, Nipple Discharge, Painful Breasts w/ Menses, Enlarging Breasts (Men)

History of Environmental Exposure: Heavy Metals, Smoke, Infections, Toxins, Mold, Pet Allergies, Food Allergies

Please explain ANY of these that apply to you:

Please tell me how many:

- Hours do you sleep at night? Wake up Tired or Rested?
- Times do you get up at night to urinate? Because your Spouse is snoring?
- Meals / day do you consume 0 1 2 3 4 5+ Candy? Snacks? Coffee? Soda?
- Energy Drinks? Daily 3x per week 2-3x per day
- Bowel Movements do you have per week?

Please indicate any Medical Contacts prior to your office visit with us today:

Primary Care OB/GYN Hospital / ER Specialist _____

Chiropractor Acupuncturist

When?

What was that office visit for?

Please list any tests that you've had done: Blood Work CT/MRI Scan X-Ray Biopsy

Have you started any new medications? Yes No

If so, what is it for? _____

Allergies to Medications:

No Medication Allergies

Food or Environmental Allergies? _____

My Current Medications (Rx and Over the Counter) are:

My Current Supplements **that I am taking** are:

Vitamin D3

Vitamin C

Vitamin B-Complex / 12

Cholestaless Polycosanol

Diaxinol Co-Q10

Immunokinoko
CSI MSM Oxygen Boost