THRIVE
LIFE CENTER

**Name:**_____ **Date:** _____
**DOB:**_____ **Gender: M F Age:**_____

**Home Address:**
_____

**Contact: Cellphone** _____**Home** _____
**Email**_____
**Emergency Contact (name and number):**_____

**How do you prefer to be contacted?** _____
**Preferred pharmacy location and fax:** _____
**What are your goals for this consultation?**

_____
_____
_____
_____
_____

**Health concerns -** Please list in order of importance.
Rate severity (1 is low severity, 10 is high)

1.

2.

3.

**Past Medical and Surgical History:** Please indicate year of diagnosis and procedure.

1.

2.

3.

4.

5.

**Obstetric and Gynecology History:**
Age of first menstruation. Regular or irregular?

Pregnancy (year and delivery if Cesarian or vaginal)

Any history of miscarriage?
Date of last menstruation:
Days of cycle:
Any PMS symptoms? If yes, please describe.
When was your last women's health check (pap)?
History of STD?

**Healthcare professionals involved in my care:**

_____
_____

**Last immunizations: (please give date of most recent vaccination or series completion date)**

Tetanus: _____ Hepatitis B: _____ Hepatitis A: _____ HPV: _____
Influenza: _____ Pneumonia: _____ Shingles: _____

**Drug or Food Allergies: (Name and reaction)**

_____ _____ _____
_____ _____ _____

**Family History:**

| Relative (ex. Father or Mother) | Medical condition/s (ex. Diabetes or Cancer) |
|---|---|
| | |
| | |
| | |
| | |

**Please list all medications, vitamins and supplements you are currently taking:**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

**Please circle any of the medications and/or supplements you have taken within the last six months:**

| | | |
|---|---|---|
| Pain Relievers | Antacids | Antibiotics |
| Appetite suppressants | Birth control | Blood pressure |
| Hormones | Insulin | Laxatives |
| Sedatives | Sleeping | Steroids (prednisone) |
| Thyroid | Tranquilizers | |
| Supplements: | | |

**What complementary and alternative therapies have you experiences or explored?**

_____

_____

**Preventive Health Status: Month and year**

Pap smear: _____
Mammogram: _____
Bone density test: _____
Colon cancer screening: _____
Dental Exam: _____
Eye Exam: _____

**Personal and social history:**

Education:_____
Occupation:_____
Marital status: **c** Single **c** Married **c** Domestic Partnership **c** Divorced **c** Widowed
Hobbies/Interests:_____
Who do you live with at home:_____
Have you been in a relationship where you were hurt, threatened or made to feel afraid? Yes No
Do you drink alcohol? yes no
How many per week? _____ Quit/When _____
Do you use tobacco? yes no
How much and for how long? _____ Quit/When _____
Do you drink caffeine? yes no
How much per day?_____
Have you used drugs? yes no
Which ones? _____ Quit/When _____
Do you exercise? yes no
Type: _____ How often? _____

**Nutrition evaluation**
Do you follow a diet? yes no
Please describe: _____
What foods do you eat on a regular basis? *Please list below.*

How many of your meals each week are prepared in a restaurant? _____
Where do you usually shop for your foods?_____
What are your favorite cooking oils and spreads?_____
How many servings of fruit do you consume each day?_____

**With whom do you live? _____**
Do you have pets?____ Are they Indoor or outdoor?_____

Please list any places you have traveled to outside of the United States and when:
_____

Overall do you feel that you get enough sleep? ___YES ___NO
Are you currently in a relationship? _____
Do you have any concerns about your sexuality? _____
Have you ever been physically, sexually, emotionally or financially abused?_____
Do you have any concerns about your current living situation (If yes, please describe)_____

What interest/hobbies do you have?_____
What physical activities do you participate in?_____
What are the major stressors in your life? _____
How do you manage your stress? _____
How do you relax? _____
What is your source of inspiration? _____
From whom do you get the greatest support in your life? _____