Be Vital
HEALTH CENTER
Optimizing Health and Performance

Tel: 434-290-1210
Fax: 434-234-9843

Be Vital Health's Intake Form

Please have this form filled and sent to us at least 2 work days before your appointment.

email us a copy with your labs/testing at admin@bevitalhealth.com or fax at 434-234-9843

For clinical management, it is very useful to gain a detailed history. The answers to these questions will allow us to develop an appropriate program specifically for you.

General Information

Date: _____ Date of your appointment:_____

Name: _____ Birth date: _____
Age: _____

Address_____

Main phone #: _____ Other phone #: _____

E-mail address: _____

I will periodically send educational and update emails. Check this box if you do not wish to receive these emails (we will only use emails for appointment information and forms if you check this box) ☐

Occupation: _____ Full-time ____ Part-time ____ Retired ____ Unemployed ____

Living Situation: Alone ___ Spouse ___ Partner ___ Friend(s) ___ Parents ___ Children ___ Other ___

Status: Married ____ Single ____ Divorced ____ Widowed ____ Other _____

How did you hear about us?

Friend/Co-worker: ___ Course/seminar: ___ Facebook: ____ Instagram: ____ Google: ____

Physician/Healthcare practitioner: ____

Please share the name of who referred you so we can thank them: _____

Article ____ Radio: 106.1/Corner _____ WINA _____ 97.9/WREN _____

Medical Status

General Health: Height _____ Weight _____ Ideal Weight _____

What was your height & weight at 25 years old if applicable? _____

Rate your general health: Excellent _____ Good _____ Fair _____ Poor _____

When during the day is your energy the best? _____ Worst? _____

Allergies and sensitivities (drugs, food, other – if a medication please list what type of reaction occurs):

_____

_____

_____

List your health care providers:

_____

_____

Last time you saw your primary care provider and for what reason?

_____

When was the last time you got blood work and for what reason?

_____

Do you currently or have you used in the past the following? If yes, please indicate how often, how much, and how long have you been using:

Alcohol		Coffee	
Cortisone/prednisone		Hormones	
Sedatives		Antacids / Laxatives	

Current Medications (prescription and over the counter) continue on the back if more space is needed:

Name of Medication	**Dosing** (how many mcg, mg, etc per tablet or capsule)	How often

Current Supplements: Vitamins/minerals, Herbals and others:

Name of Supplement with Brand	**Dosing** (how many mcg, mg, etc per capsule or tablet)	How often

Past Medical Conditions

Childhood illnesses (please list): _____

- Asthma
- Diabetes
- Heart Trouble
- High Blood Pressure
- Clotting Disorders
- Kidney Trouble
- Varicose Veins
- Thrombosis
- Stroke
- Arthritis
- Back pain
- Fractures
- Chronic Fatigue
- Osteoporosis
- Scoliosis
- Fibromyalgia
- Breast cysts
- Thyroid disease
- Alcoholism
- Colitis/Crohn's
- Lyme disease
- Eating Disorder
- Anorexia
- Gallstones
- Liver disease
- Epilepsy
- Loss of teeth
- Rheumatoid arthritis
- Hyperparathyroidism
- Hormone disorders
- Other_____
- Cancer, breast
- Cancer, colon
- Cancer, uterus
- Cancer, ovaries
- Cancer, other _____

Pertinent details:

_____

Surgery or major hospitalizations:

Surgery or reason for hospitalization	Year

Please list the most significantly stressful events in your life?

1)_____ Date: _____

2)_____ Date: _____

3)_____ Date: _____

4)_____ Date: _____

5)_____ Date: _____

Family History

Please list the ages, health problems and if deceased, cause of death:

	Problem	Alive/deceased	Cause of death if applicable
Mother			
Father			
Brothers			
Sisters			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			

Do you have any blood relative such as aunt, uncle, cousins who have/had any of the following?

allergies	arthritis	asthma	cancer	diabetes
anemia	depression	skin disease	heart attack	genetic conditions
high blood pressure	stroke	ulcers	cataracts	thyroid
high cholesterol	seizures	sickle cells	mental health conditions	autoimmune conditions
hypoglycemia	Alzheimer's	blood disorders	dementia	
Lyme disease	other			

Personal Habits & Nourishment

What do you enjoy most in your life currently? _____

What are your main interests and hobbies? _____

What do you worry about most in life? _____

Do you exercise? If so what kind? _____

Do you have a religious or spiritual practice ? If yes, please describe

_____

Do you feel supported in your healing options and community? _____
What do you use for your drinking water? **(*bottled, filtered, or tap water, well*)** and how many oz water per day?

_____
Other beverages: What kind ? And how much? _____
Do you normally feel warmer or cooler compared to others? ***(cool or avg. or warm)***
If you are working, do you enjoy it ? _____ Do you take vacations? _____
Are you currently in a satisfying relationship?_____

Personal History - Please use this page to type or <u>write clearly</u> a personal timeline/summary of symptoms and treatments you've tried.

<u>Please use bullets</u> to organize things and include the following:

Onset: when did this concern start/begin, when did it get worse
Location of pain/discomfort in the body if applicable
If symptom comes and goes, how long does it last
Things that make it better or treatments that have helped
Things that make it worse and treatments that have not helped

Medical Symptom Questionnaire (MSQ)

reproduced and modified from the Institute for Functional Medicine

Rate each of the following symptoms based on <u>your typical health profile for the past 14 days</u> (we want to know current symptoms, <u>not past symptoms from 6 mo ago</u>).

Point Scale

0 – ***Never or almost never*** have the symptom **1** – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe*** **3- *Frequently have it, effect is not severe***
4 – *Frequently have it, effect is severe*

Please remember this applies for the last 14 days

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **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**_____

Ears
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **Total**_____

Nose
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **Total**_____

Mouth/Throat
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores **Total**_____

0 – ***Never or almost never*** have the symptom **1** – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe*** **3- *Frequently have it, effect is not severe***
4 – *Frequently have it, effect is severe*

Skin
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ Lack of sweating/inability to sweat
_____ Cold hands and feet **Total**_____

Heart
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain **Total**_____

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total**_____

Kidney & Bladder
_____ Recurrent bladder infections
_____ Burning sensation during urination
_____ Urine has a strong odor
_____ Difficulty starting or stopping urination **Total**_____

Digestion
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **Total**_____

Other digestive questions - do not use to add up in the total
Have you traveled outside the U.S. in the last 5 years? ***(yes/no)***
Have you ever lived outside the U.S.? where?_____
How many bowel movements do you have in a week?_____

0 – ***Never or almost never*** have the symptom **1** – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe*** **3- *Frequently have it, effect is not severe***
4 – *Frequently have it, effect is severe*

Joint/muscle
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness **Total**_____

Weight
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight **Total**_____

Energy/Activity
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Poor sleep or insomnia
_____ Restlessness **Total**_____

Mind
_____ Poor memory or have "brain fog"
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities **Total**_____

Emotions
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **Total**_____

Other
_____ Frequent illness
_____ Frequent, urgent urination or painful bladder
_____ Numbing and tingling in extremities **Total**_____

Grand Total_____

Fatigue - Adrenal Dysfunction Screening

Check with ✓ only ones that apply (1 point for each selected)

	Are you tired/fatigued almost every day, especially in the afternoon?
	Do you have a hard time falling asleep at night or have insomnia?
	Do you wake up frequently during the night?
	Do you have a hard time waking up in the morning early, or feeling refreshed?
	Do bright lights bother you more than they should?
	Do you startle easily due to noise or does noise bother you more than it bothers others?
	Do you take things too seriously, and are easily defensive/irritable?
	Do you feel you don't cope well with certain people or events in your life or get stressed very easily?
	Do you get panic attacks (heart racing, dry mouth, sweating, nausea, light headedness, feel out of breath, trembling, feel out of control)?
	Do you feel down/depressed or have been diagnosed with depression?
	Do you often get sick, more than most people?
	Are you exhausted for days after a very busy period of time, high stress, traveling that includes jet lag?
	Do you crave salt or salty foods?
	Do you often get dizzy/lightheaded when you get up quickly? Or have been told you have low blood pressure?
	Cannot tolerate exercising like you used to or get a lot more fatigued during and after exercise?
	Has your appetite decreased and have you lost weight without trying in the last few months?
	Are you sensitive to opioid pain and sedative medications?
	Do you experience "low blood sugars" or sugar cravings?
	Do you find you need more and more caffeine every day then you did in the past?
	Do you have allergies (environmental, cat/dog, etc)?
	Total (1 point for each selected)

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention. Your total score is based on a scale of 0 to 24. **When you finish the test, add up the values of your responses.**

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations if given the opportunity? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

No chance of dozing = 0
Slight chance of dozing = 1
Moderate chance of dozing = 2
High chance of dozing = 3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total score	

Interpretation:

0: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

This printed version of the Epworth Sleepiness Scale is provided courtesy of Talk About Sleep, Inc. www.talkaboutsleep.com.

Toxin Exposure Screening

One point for every mark. Add points at the bottom	Yes	No
Living/work/school Environment		
Are you often exposed to chemicals such as adhesives, paints/varnishes/solvents, welding/soldering materials or other air borne chemicals?		
Does your home or workplace have visible mold, water damage, damp windows, or basement or crawlspaces? Or had to be remediated for mold at any point?		
Have you ever been exposed to known heavy metals including mercury (broken mercury thermometers) or lead (lead paint or dust)?		
Does your home or workplace have cracking paint or decaying insulation or foam?		
Have you lived in a very old or brand new home?		
Do you frequently use "regular" cleaning products, disinfectants, hand sanitizers, air fresheners		
Are you frequently exposed to pesticides, fungicides or insecticides?		
Do you live or work near a cell phone tower, power lines or feel poorly when around these including Wi-Fi?		
Diet		
Do you consume conventionally grown (non-organic) produce?		
Do you consume conventionally raised (non free-range or non-organic) animal products?		
Do you consume fast foods 2+ times per week?		
Do you consume sodas or sports drinks 2+ times per week?		
Do you drink water from a well, spring or from plumbing installed before 1986?		
Others		
Do you smoke or are/have been exposed to second hand smoke?		
Have you had a root canal		
Are you chemically sensitive – feel irritated around smoke, perfumes, gasoline or regular cleaning products?		
(One point for every mark) **Total**		

Adverse Childhood Experience - ACE

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___If Yes, enter 1 __
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___If Yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___If Yes, enter 1 __
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No___If Yes, enter 1 __
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___If Yes, enter 1 __
6. Were your parents ever separated or divorced?
   No___If Yes, enter 1 __
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___If Yes, enter 1 __
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___If Yes, enter 1 __
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? No___If Yes, enter 1 __
10. Did a household member go to prison?
    No___If Yes, enter 1 __

Now add up your "Yes" answers: _____ This is your ACE Score