

DATE: \_\_\_\_\_



Please fill out the first 2 pages (front and back) and provide to your health consultant.

**This form is confidential.**

Successful health care and preventative medicine are possible when there is a thorough understanding of the physical, mental, emotional, and spiritual concerns at hand. If any of the following questions are difficult to answer please let Dr. Schikowitz know.

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender (sex): \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ How late can you be called? \_\_\_\_\_

Email address: \_\_\_\_\_ May I send you information via email? \_\_\_\_\_

Present Health Concerns (in order of importance): \_\_\_\_\_ Duration: \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What level of change to your living habits are you willing to make to improve your health? (circle one):

*Whatever it takes*                      *Significant change*                      *Some change*                      *No change*

Diet history (include any liquid tea, coffee, etc., in description.):

What is a typical breakfast? \_\_\_\_\_

What is a typical lunch? \_\_\_\_\_

What is a typical dinner? \_\_\_\_\_

List snacks you had yesterday: \_\_\_\_\_

How many glasses of **plain water** do you drink/day? \_\_\_\_\_ Filtered    Tap    Distilled    Well Water

Do you practice any special diet restrictions? \_\_\_\_\_  
\_\_\_\_\_

Describe your ideal doctor or healthcare provider: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Vitamins /Herbs/Supplements that you are now taking:

Name / Type	Reason for taking	Dose/day (mg/etc)	For how long	Who prescribed

Prescription and over-the-counter, that you are now taking:

Name of drug	Reason for drug	Dose (mg/etc)	For how long	Prescribing doctor

Using the following key, designate which family members have had the following. List type where parentheses are present:

M = Mother    F = Father    B = Brother    S = Sister    G = Grandparent    C = Child

Condition	Who	Condition	Who	Condition	Who
Allergies		Diabetes		Kidney disease	
Alcoholism		Cancer (            )		Mental disorder (            )	
Anemia		Cancer (            )		Obesity	
Arthritis(Rheumatoid)		Epilepsy		Stroke	
Arthritis(Osteo)		Heart Disease		Thyroid (low/ high)	
Auto Immune disease		High Blood Pressure		Other: (            )	
Bleeding tendency		High Cholesterol		Other: (            )	

Anything else I should know about you?

Subject to the terms of this disclaimer and release, we are pleased to offer you one of our services in the Omega Wellness Center. We have explained the nature of the treatment to you and you have elected to receive that treatment.

Your treatment is not intended to diagnose any physical or mental condition or to prescribe or promote any particular product. It is not intended as a substitute for the advice and treatment of a licensed physician.

If you are uncomfortable during any portion of your treatment, advise your practitioner immediately.

You are participating in the treatment of your own volition, and you accept and assume any and all risks associated with, or consequences relating to, the selected treatment. You waive any claims you may have against Omega, its employees, practitioners, officers and directors, relating in any way to the treatment.

Signature \_\_\_\_\_ Parent/Guardian Signature (when applicable) \_\_\_\_\_ Date: \_\_\_\_\_

**Your signature on this page indicates you have read, and are in agreement with, the release of liability statement (above) which covers any Wellness Center services you partake in during the course of your stay at Omega. If you are under the age of 18, then a parent/guardian of the above-named child/youth must co-sign this form.**

Review of Systems for: \_\_\_\_\_

**Checked box = significant history. Please circle appropriate symptom and record details at right.**

**General**

- Weight change     Fever / Chills     Weakness  
 Fatigue     Heat / cold intolerance     Thirst  
 Hands/ feet cold / hot     Sweat / Night sweats

**Sleep**

- Trouble Falling     Trouble staying  
 Wake rested

**Skin**

- Rashes     Itching     Hair/nail change  
 Dryness     Bruising     Yellow

**Head**

- Headache     Trauma

**Eyes**

- Vision/glasses     Blurring     Floaters  
 Diplopia     Pain     Discharge     Dry Eyes  
 Night Vision

**Nose**

- Sinusitis     Discharge     Postnasal drip  
 Bleeding     Obstruction

**Mouth/Throat**

- Sores     Teeth     Dentures  
 Gum bleeding     Hoarseness     Taste

**Lungs**

- Short of Breath     Wheezing     Coughing blood  
 Chest pain     Cough     Excess Phlegm

**Breasts**

- Masses     Pain     Discharge

**Cardiovascular**

- Palpitation     Swelling ankles     Hypertension  
 Short of breath when reclining     Pain with walking distances  
 Pain     Murmurs     Turning blue  
 Trouble catching breath

**Gastrointestinal**

- Poor appetite       Pain       Indigestion  
 Turning Yellow       Hernia       Trouble swallowing  
 Blood/mucus in stool       Constipation       Anal discomfort  
 Hemorrhoids       Gas / bloating       Food sits in Stomach  
 Nausea/Vomiting/Diarrhea       BM brown, well formed

**Genitourinary**

- Painful Urination       Wake to urinate       Blood in urine  
 Frequent urination       Urgent urination       Incontinence

**Sexual History**

- Syphilis       Gonorrhea       Chlamydia  
 Herpes       Sores/Discharge       Yeast Infections  
 Impotence       Contraception  
 Testicular pain/swelling       Pregnancies

**Female-menses**

- Painful Menses       Menopause       Spotting  
 Irregularity       Cycle duration/Amount

**Endocrine**

- Goiter       Tremor       Diabetes  
 Heat/Cold intolerance       Hormone therapy

**Allergic**

- Asthma       Hay fever       Hives  
 Eczema       Sensitivity to allergens/drugs/vaccines

**Bones, joints & muscles**

- Trauma       Swelling       Pain/Arthritis

**Blood-lymphatic**

- Anemia       Transfusions       Bleeding tendency  
 Lymph node enlargement/pain

**Neurologic**

- Fainting    Convulsions    Gait/Coordination  
 Sensations    Speech    Paralysis/Weakness

**Psychological**

- Memory loss    Mood changes  
 Anxiety/Depression    Phobia  
 Sleep pattern    Drug/Alcohol abuse

**Other:**

- Hx antibiotic use    Diet    Caffeine    Alcohol

**Patient Name:**

**DOB:**

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