Abundant Life Wellness Center
A HOLISTIC HEALTH CENTER

3904 Boat Club Road
Lake Worth, Texas 76135
817-847-0900 office
www.abundantlifewellnesscenter.com

Date:

First Name: Middle Name: Last Name: Date of Birth:

Email:

Cell Telephone Home Telephone Work Telephone

Weight/Height

If Minor, Name of Parent(s)/Guardian(s)

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Student ☐ Widowed

Name of Spouse:

Total # of Children:

Girl's ages:

Boy's ages:

Emergency Contact Person (Relationship) and Telephone Number

Your Occupation:

Name of and Telephone number of your Employer:

Our referral program includes a free follow up visit for the person who referred you to our office! Please list the 1st person that referred you to our office:

Your Health Concerns

What is the main reason you are seeking help today?

Duration of this condition?

What do you believe caused this condition?

When were you last seen by a physician?

For what purpose did you see the physician?

How many hours of sleep do you get each night?

Do you feel rested upon waking?

List all dental work you have ever had done or that you need to have done with the exception of regular cleanings:

List any foods that you crave:

List any known allergies or anaphylactic reactions to foods, drugs or environmental items:

List any special diet or dietary restrictions:

Describe your hobbies and interests:

What is your overall level of satisfaction with life?

Would you say that you are under a lot of stress?

What methods do you use to alleviate or cope with stress?

Describe any significant accidents, injuries, or illnesses in the past:

List any other hospitalizations or surgeries you have had, and your age at the time:

Did you have any of the following childhood diseases?

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Frequent Ear Infections
- ☐ Rashes

Other, including any unusual childhood diseases:

What vaccinations, including flu shot, have you ever received? Please provide approximate dates.

Do you have any scars on your body? If so, where are what are the cause?

Family History

Please check all that apply:

	You	Children	Parents (which one)	Siblings
Allergies				
Arthritis				
Asthma				
Cancer				
Diabetes				
Heart Disease				
Kidney Disease				
Liver Disease				
Lung Disorder				
Osteoporosis				
Mental Illness				
Substance Abuse				
Stomach Disorder				

Depression				

Other

Is your mother still alive?

- Yes
- No

If not, what was her age and reason for passing?

Is your father still alive?

- Yes
- No

If not, what was his age and reason for passing?

Is there any other information you would like to share about your health that you feel would be beneficial to us?

Name and Location of Other Practitioners You See

MD:

Acupuncturist:

Chiropractor:

Massage Therapist:

Other:

5-Day Food Log

Please fill out your 5-day log. Please write out a typical daily diet. (Note: it is helpful to describe both a good and bad day's eating habits.)

	Breakfast/Time	Lunch/Time	Dinner/Time
Day 1			
Snacks			
Day 2			
Snacks			
Day 3			
Snacks			
Day 4			
Snacks			
Day 5			
Snacks			

Additional information about your food log