Larsen Wellness Center

Health By Choice, Not By Chance

Step One: Please take the time to fill out the health history questionnaire that follows as accurately as possible. Your answers are very important and will provide an understanding of your current symptoms, personal history, and health goals. The more information we have, the more effective Dr. Larsen will be in treating you.

Step Two: The Doctor will review your questionnaire responses and discuss them with you.

Step Three: An examination will then be conducted to determine a diagnosis and if our methods of health care are appropriate for your condition. You will be advised as to whether additional procedures such as laboratory testing or x-rays are recommended.

Step Four: When you return for your Report of Findings on your second visit, the Doctor will inform you of the results of your exam and suggest appropriate treatment.

Step Five: Once you clearly understand your case and diagnosis, customized treatment will be recommended. Your treatment plan will be tailored to your diagnosis and health goals. When you are comfortable with the findings and recommendations, treatment can begin.

Our goal is to help you achieve your health goals as quickly and reasonably as possible, so your body will function as it was created to.

Thank you for choosing Larsen Wellness Center!

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New Patient Information

Personal Information

Full Name:	D.O.B: (MM/DD/YY)
Street Address:	
City, State, Zip:	
Email:	Receive Office Newsletter: Y N
Home Phone:	Cell Phone:
Age: Height: Weight:	Occupation:
MARTIAL STATUS: M W S D PREGNANT: Y N	PREFERRED TO BE CALLED:
Blood Type: A B AB O Referred By:	
Emergency Contact Information:	

Primary Health Concerns

List Your Health Concerns According to Severity	Rate Of Severity 1= Minimal 10= Unbearable	When Did It Begin?	Have You Ever Had This Before?	% of the Day That Symptoms Are Present?	Better? Worse? Same?
1)					
2)					
3)					
4)					
5)					

Family Health History (You, Children, Parents, Grandparents, Siblings)
Please Circle All That Apply

- ADD/ADHD
- Arthritis
- Asthma
- Auto-Immune Disorder
- Bi-Polar Disorder
- Bleeding Disorder
- Blood Pressure Problems
- Cancer
- Childhood Diseases
- Chronic Fatigue
- Diabetes
- Dizziness
- Emotional Distress
- Fibromyalgia
- Hearing Problems
- Heart Disorder
- Hepatitis
- Hernia
- Liver Disorder
- Memory Problems
- Nausea/Vomiting
- Neurologic Disorder
- Numbness
- Osteoporosis/Bone Density
- Pacemaker
- Pneumonia
- Restless Leg Syndrome
- Seizures
- Stomach Pain/Discomfort
- Suicidal Thoughts/Actions
- Thyroid Problems
- Tremors/Shaking
- Tumors/Growths
- Vision Problems
- Other_____
- Other_____

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Diagnostic Tests (Please Bring ALL Reports With You, Or Fax To 651-982-1855)

Type of Test (Blood Work, X-Ray, MRI, etc)	Date of Test	Positive Findings
1)		
2)		
3)		
4)		

Received a Diagnosis For ANY Condition By Another Health Care Provider? Y N

If Yes, What Was The Diagnosis? _____

Who Provided The Diagnosis? _____

Other Health Care Providers (Even if your concerns are unrelated to the doctor's speciality)

Name:	Type of Doctor:
Address:	
Reason For Care:	
Did It Help:	Are You Still Seeing Them:
What Did They Do:	

Name:	Type of Doctor:
Address:	
Reason For Care:	
Did It Help:	Are You Still Seeing Them:
What Did They Do:	

Health Goals (what **YOU** wish to achieve by being a patient in our office)

Daily Activities: Please describe in detail the affects the health concerns or diagnosis have on your daily life (for example: work, pleasure, recreation, hobbies, sleeping, etc.)

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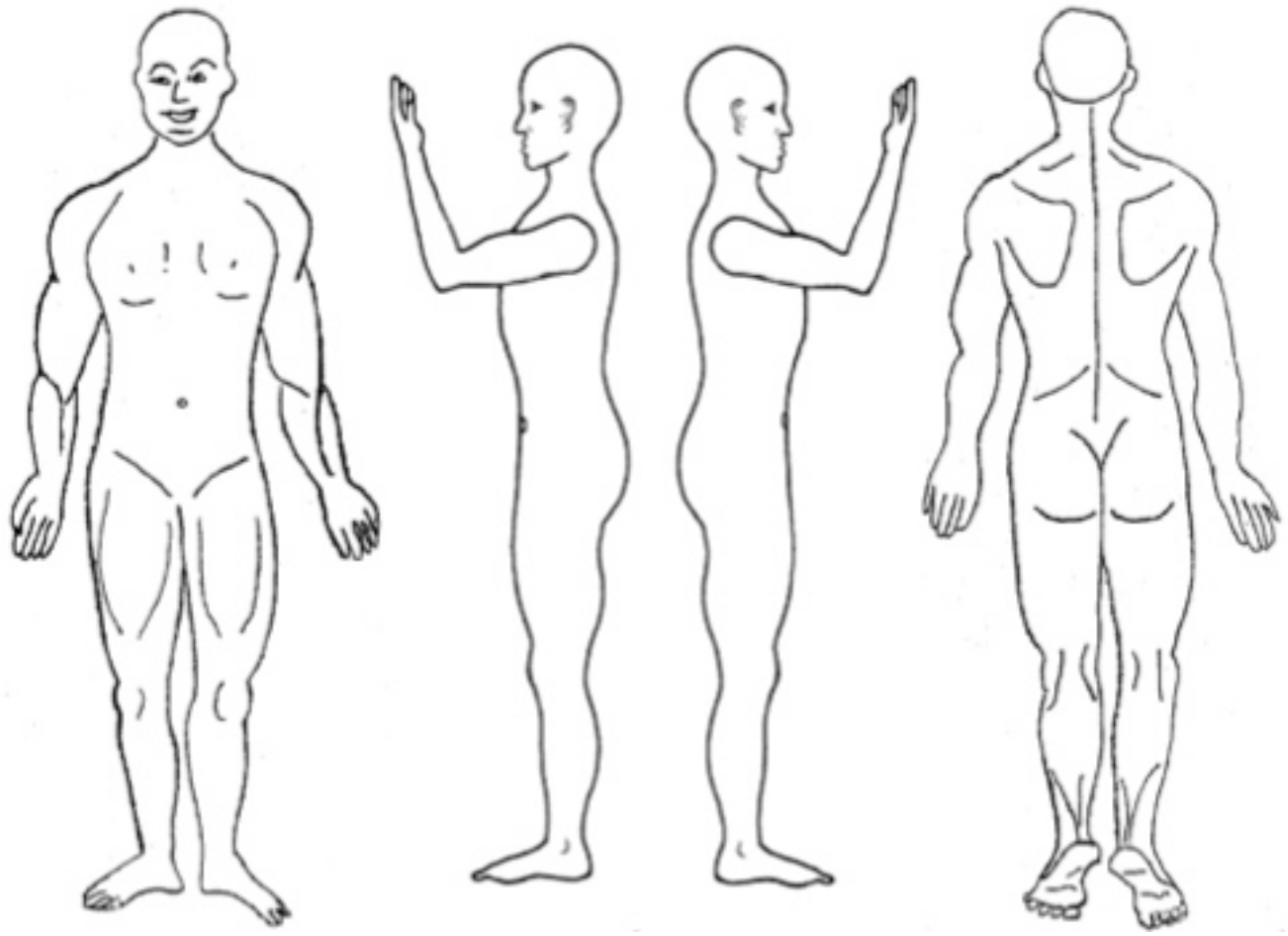
SCAR / TRAUMA CHART



Directions

All Scars: Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, vasectomies, etc.

All Trauma Areas: Please put a red"X" where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects, such as surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury: Draw a line form each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988")

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Medications and Supplements

Please list ALL medications and supplements that you are taking, the reason you are taking them, and the person that prescribed them to you (including yourself). This includes over the counter, prescription, recreational, vitamins, herbs, etc. Please bring all medications and supplements you are currently taking to your initial consultation.

Medications	Prescription?	Who Prescribed?	Reason
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		

Supplements	Reason

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PLEASE CIRCLE ALL THAT APPLY TO YOU:

Headaches: Base of skull / Temples / Cluster / Top of head / TMJ (jaw) / Front of head / Migraine / Behind eyes

Ears: Noise (Ring/Hiss/Pound) / Plugged / Pop / Ache / Drain / Itch / Hearing Loss / Dizzy / Vertigo / Excess wax

Eyes: Burn / Tear / Ache / Red / Dry / Filmy / Itch / Blurry vision / Floaters / Spots in vision / Tired / Puffy / Stye / Twitch / Dark circles under eyes / Problems driving at night or Night blindness

Sinus: Dry / Drain / Plugged / Mucus (White/Yellow/Green/Gray/Brown/Clear) / Sneeze / Smell loss / Taste loss / Thirsty / Bleed

Throat: Sore/Hoarseness

Neck: Stiffness / Tension / Difficulty swallowing / Swollen glands

Mouth: Dry / Productive (cough) / Upper respiratory tract infection / Fever / Chills / Bad breath / Canker sores / Fever blisters

Lips/Teeth: Cracked lips / Dry mouth / Teeth Grinding / Bleeding gums (when brushed or flossed) / Loose teeth / Root canals / Metal fillings / Extracted Teeth / Bridges / Braces / Retainer / other metals in mouth

Chest: Tension / Tightness / Pressure / Heaviness / Congestion / Pain / Angina

Shortness of Breath: Constant / With exertion / Asthma / Wheeze / Air hunger / Always yawning

Heart: Palpitations / Mitral Valve Prolapse / Heartbeat to fast / Heartbeat to slow / Murmur / Arm pain / Pacemaker

Digestion: Heartburn / Indigestion / Aches after eating / Cramps / Nausea / Queasy / Bloat / Gas / Belch / AnalItching / Stomach ulcers / Hiatal hernia

Bowels: Regular (_____ bowel movements per day) / Sluggish (every _____ days) / Cramps / Hemorrhoids Need Laxatives / Use Suppositories / Need Enemas

Fecal Consistency: Soft / Ribbons / Mucous / Normal / Hard / Pebbles / Dry / Pain / Diarrhea / Constipation

Breast: Feeding / Fibroids / Lumps / Discharge / Prosthesis / Augmentation / Reduction / Tenderness

Legs/Feet/Arms/Hands: Cramping (charlie horse) / Spasm / Rash / Acne / Dry / Itch / Fungus / Fluid retention / Cold / Sweaty

Urination: Wake up at night to urinate / Frequency during day / Urgency / Burning / Pain / Odor / Spasm Leaky bladder / Urinary tract infection

Sleep: Difficulty falling asleep / Insomnia / Interrupted / Dream / Nightmares / Night sweats / Restlessness

Emotional (more than normal): Sad / Grief / Depression / Moody / Irritable / Worry / Angry / Nervous / Frustrated / Anxiety / Panic / Cry / Fear / Shame

Appetite: Normal / Low / High **Cravings**: Sweet / Coffee / Chocolate / Alcohol / Soda / Salt / Crunchy / Other

Energy: Normal / Low / High / Variable / Slow to start **Sexual Drive:** Flat / Low / Normal / Impotent Memory/

Coordination/Concentration: Normal / Decreased **Slow Healing/Bruise Easily**: Yes / No

DO YOU CONSUME: Alcohol / Tobacco / Recreational Drugs / Coffee / Tea

DO YOU EXERCISE: Yes / No

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WOMEN ONLY:

Menses: Regular / Irregular – Every _____ days **Birth Control:** Yes / No

Flow: Heavy / Moderate / Light / Long (7+ days) / Brief (<3days) / Spotting / Clots

Fluid retention: Face / Hands / Feet / Body / Abdominal puffiness **PMS:** Mood swing / Irritable / Depression

Cramps: Mild / Moderate / Severe / Stomach / Back / Heavy Bladder **Acne:** Before / During / After / Oily Skin

Ovulation: Pains/Cysts/Discharge/Regular/Irregular/Fibroids **Difficulty Losing Weight:** Yes / No

Vagina: Burn / Itch / Dry / Pain / Painful Intercourse **Discharge:** Clear / White / Yellow / Green / Brown

Menopause: Natural / Surgical (Partial/Complete) / Hormone replacement / Hormone patch / Hot flashes

History of Miscarriage: Yes / No **Difficulty Getting Pregnant:** Yes / No **C-Section:** Yes / No

MEN ONLY:

Prostate: History / Current / Burn / Ache / Pain / Restricted / Dribble / Nocturnal emission / Swollen Erectile dysfunction

History of Miscarriage (your female partner): Yes / No **Infertility:** Yes / No

Difficulty Getting Pregnant (your female partner): Yes / No

List ALL Organs/Glands/Body Parts That Have Been Removed From Your Body:_____

_____

Please Include Any Additional Information You Feel We Should Know:

_____

_____

_____

_____

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