Anne Dunev, PhD
Well Body Clinic
178 S. Victory Blvd., Suite 205
Burbank, CA 91502

Name: _____
Appointment Date_____Check In Time_____
Date of Birth:_____Age:_____
Address:_____
_____ City:_____State:_____
Zip:_____ Phone Number_____
Home_____Alternate:_____Occupation:_____
_____
Email:_____Newsletter Ok?_____
SS# (billing purposes)_____ Emergency
Contact:_____ _____
Name of and address of Person Responsible for payment of services if other than above: _____
How did you find our clinic?
_____

Are you ready and willing to make life style changes that will impact your over-all health? _____ Have you ever seen a Holistic Health care provider?
_____

Welcome to the Well Body Clinic. In order to provide you with the best health care and assist you with other details of our clinic we have provided the following information. We appreciate your assistance in completing the intake paper work. You will find a list of our office policy on the next page.
We will kindly require you to pay for our services at your appointment. We accept checks, cash and all credit cards.
CANCELLATION POLICY:
24 hours notice is necessary for cancelled appointments. This allows space for others who may need appointments. We reserve the right to bill for missed appointment.
DISPENSARY:
Our supplement dispensary is open to serve you during office hours Monday through Friday 9:00am – 5:30pm and Saturday by appointment.
RETURN POLICY:

No opened dispensary items can be returned for credit. Un-opened items can be returned in special circumstances within 5 business days of purchase for credit on account only. A 25% restocking charge will be deducted from the amount after the 5th day.

SCENT POLICY:

Many individuals visiting our office are extremely sensitive to odors, chemicals and other products. Because of this, we ask that you please refrain from wearing any cologne, perfume, aftershave, or any other scented products (i.e.: fabric softener/bounce) when you come to our clinic. We use a high quality HEPA air filtering system.

WHAT TO EXPECT ON YOUR FIRST VISIT:

Naturopathic and nutritional medicine takes time to search for the underlying cause of your illness or symptoms and to not just provide you with symptomatic relief. Because of this, please be prepared to take the time necessary to give us a detailed history, to review body systems, and to come up with an individualized treatment plan for you. If you do not understand your treatment or are having problems with following your treatment plan, then we encourage you to call us, so that we can help you appropriately.

Please list the concerns you have that you would like to discuss

1. _____
2. _____
3. _____
4. _____
5. _____

Please list how you have addressed your concerns:

_____

_____

HOSPITALIZATIONS / SURGERIES:

INCIDENT and DATE_____

_____

Please bring copies of most recent laboratory result to your appointment.

PERSONAL MEDICAL HISTORY (circle any history of these health issues)

TUBERCULOSIS SCARLET FEVER RHEUMATIC FEVER VENEREAL
DISEASE EPILEPSY / SEIZURE DISORDER MENTAL ILLNESS / DEPRESSION
CANCER
GOUT /ULCER/ LYME DISEASE
ARTHRITIS/ KIDNEY DISEASE/ LIVER DISEASE/ GASTRO-INTESTINAL DISORDER/
GENITO-URINARY DISORDER /SEXUAL
DYSFUNCTION/ ANEMIA /HYPERLIPEDEMIA-CHOLESTEROL/ MS
MENSTRUAL DYSFUNCTION/ DIABETES/ THYROID DISEASE/ FATIGUE
BRONCHITIS / EMPHYSEMA ASTHMA ALLERGIES / HAY FEVER SHORTNESS OF
BREATH
DIZZINESS / FAINTING CLAUDICATION HEART ATTACK HEART MURMUR
CONGENITAL HEART DISEASE /CONGESTIVE HEART FAILURE/ HIGH BLOOD
PRESSURE/ ARRHYTHMIA/ STROKE / TIA'S
Body Systems Check – Circle your current problems: Current Weight_____ Height
_____

Sleep – Problems falling asleep / Freq. waking / Early waking / Wake un-refreshed / Sleepy / Night sweats General – General run down' feeling / Frequent colds/flu / Nausea / Swelling/ Edema / Swollen Glands Head – Headaches / Migraines / Panic attacks / Scalp Issues / Hair loss Eyes – Blurred vision / Itchiness / Spots / dryness/ Glaucoma / Photosensitivity Ears – Hearing difficulty / Infections / Itchy ears/ Sound sensitivity / Wax build up / Ringing Ears Sinuses – Sinusitis / Congestion / Dripping / Phlegm / Allergies Lungs / Heart – Breathing Difficulty / Infections / Palpitations / Chest pain/Angina / Arrhythmias/ Blood pressure Muscle & Joints – Pain / Inflammation / Back/neck/shoulder aches / Lack of mobility / Muscle weakness Nerves – Pain / Burning / Numbness / Tingling / Sensitivity / Dizziness Bladder -Pain / Frequent night visits to toilet / Infections / Stress incontinence How often do you pass stools ? Times per day_____ Stools tend to be: Loose / Formed / Constipated / Alternating / Blood / Discolored stools Digestion - Abdominal pain / Gastric reflux/ Difficulty swallowing/ Food cravings Skin – Eczema / Psoriasis / Rash / Itchiness / Dryness / Spots / Athlete's foot/ Moles / Weak nails Cognitive – Poor concentration / Memory /

Comprehension / Disorientation Mood – Depression / Anxiety / Irritable
Other:_____
Married____ Single_____ Number of Children____
Men : (circle what applies) Prostate problems, Sexual impotence, Lack of libido, Genital discharge, Testicular Pain Vasectomy, Herpes,
Other_____
Women : No. of births:_____ No. of miscarriages: ___ No. of abortions:____ Use/ON birth control: _____
Menstruation has been (circle): Regular, Irregular, Absent. Length: every _____days, for_____. Heavy/Light Menopause: Started age_____ Have you used hormones? Yes____ No____ Symptoms?_____
Other details (circle): Infertility Pregnant now Menopause Breast Lump Abnormal Mammogram Low Libido

DENTAL HISTORY:
Do you get regular dental care?_____ Current no. of dental amalgams _____
How long since the first one was placed_____ Total number that have been removed: _____ When removed? _____ Removed (a) by a regular dentist or (b) by a holistic mercury-free dentist? Did your mother have amalgam fillings before your birth? Yes____ No___ Not sure_____
No. of gold caps__ root canals___ or other dental restorations _____
Do you have any current dental issues?_____

TOXIC ENVIRONMENTAL EXPOSURES: Do you smoke? Yes___ No___ Have you been exposed to second hand smoke? Yes___ No___
How much do you smoke?____ When did you quit?_____
Do you live near any of the following? Mobile phone tower: High power generator: Crematorium:
Industrial zone: Polluting factory: Nuclear plant: Golf course
To your knowledge, have you ever been exposed to any other major environmental toxins? (Circle exposures)
Dry cleaning: Moth Balls: Fabric Softener: Paint: Scented Candles: Solvents: New Carpet: Pesticides: Toxic Metals
Planning pregnancy PCOS
Abnormal Paps Herpes Endometriosis PMS Hysterectomy Cesarean STD
Exercise Routine: Type and Frequency:_____
_____
ENERGY:

Rate your energy from 1-10 _____ Morning ____ Noon ____ Night ____ Between meals____ Just after meals_____
Do you use Caffeine or other stimulates? _____ What_____ How Much?_____

Mind : Emotions : Spiritual: Check current feelings:
Happy ____Content____Joyful_____
Anxious_____ Depression___ Hopeless____
Anger/frustration____ Racing Mind_____Grief/Sadness_____
Fear____ Lonely____ Worry____Poor Concentration_____ Brain Fog_____Poor Memory_____Mood Swings___ Other_____ Medication Use/ History:_____
_____Alcohol Use_____ Marijuana Use_____ Other drugs_____ Are you currently seeing a counselor? _____

Stress: Rate your current overall stress level between 1 and 10 _____ (1 = very relaxed, 10 = very stressed) Factors most contributing to your stress: Health Work Money Family Other What best helps you deal with your stress?
_____
_____

Describe A Typical Days Diet
Breakfast:
Lunch:
Dinner:
Snacks:
Desserts: (how often)
Fluids (include type and amount)

Where do you like to grocery shop? _____How often do you eat out? _____ Do you buy Organic Foods? Yes_____ No_____
How much of the following would be found in the foods you eat on a daily basis? Synthetic sugars_____ Preservatives_____ Colors/Dyes _____Synthetic chemicals_____
Do you crave: Sugar_____ Salt_____ Fats_____ other_____ Coffee_____ How many cups per day _____ Sodas _____ Alcohol_____Street drugs_____
Medical Marijuana_____

List Your History of Food & Medication
Allergies/Sensitivities:_____
_____

SUPPLEMENT LOG Supplements: List all vitamins, minerals and other nutritional supplements

MEDICATION LOG Medications: What medications are you taking now? Include non-prescription drugs?

SYMPTOM SURVEY FORM

PATIENT _____ DOCTOR _____ DATE _____

INSTRUCTIONS: Number the boxes which apply to you with either a 1, 2, or 3.

(1) for MILD symptoms (occur once or twice a year)
(2) for MODERATE symptoms (occur several times a year)
(3) for SEVERE symptoms (you are aware of it almost constantly)

Leave the box BLANK if it does not apply to you!

GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meals
6 ☐ Keyed up—fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP 2

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feels "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleep—hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression—"blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed room
61 ☐ Susceptible to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black/blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

73 ☐ Dizziness
74 ☐ Dry skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movements painful or difficult
82 ☐ Worrier, feels insecure
83 ☐ Feeling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones
91 ☐ Sneezing attacks
92 ☐ Dreaming, nightmare type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets