# Karen Wright MTCM, L.Ac.

## Wright Life Wellness Center

Please complete this document as completely as possible.

### Personal Information

| Date | First | Last | Middle |
|---|---|---|---|
| | | | |

| Age | Date of Birth | Address |
|---|---|---|
| | | |

| Phone Number #1 | Phone Number #2 |
|---|---|
| Home / Work / Cell | Home / Work / Cell |

| Occupation | Work Address and Phone Number (if not listed above) |
|---|---|
| | |

| Emergency Contact #1 | Emergency Contact #2 |
|---|---|
| Name: ______________________<br>Number: ________________cell/home<br>Relationship: ____________________ | Name: ______________________<br>Number: ________________cell/home<br>Relationship: ____________________ |

Your email address and any other contact info:

______________________________________________

### Medical Information

If you have medical diagnosis, please list here:

______________________________________________

______________________________________________

______________________________________________

Please list surgical history here:

| Date | Procedure |
|---|---|
| | |
| | |
| | |
| | |
| | |

If you are seeing any other healthcare professional, please list here:

| Name | Healthcare field | Contact Information |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list current medications you are taking, including over the counter drugs:

| Name | Taken for how long? | Reason for taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

What are your most important health concerns today?

1) ______
2) ______
3) ______
4) ______
5) ______
6) ______

Of those health concerns, when and how did each one begin? (i.e. “2002”, car accident”)

1) ______
2) ______
3) ______
4) ______
5) ______
6) ______

Have any of your family members experienced health disorders (physical, mental or emotional)? Please identify member (mother, father, maternal grandmother, husband or wife) and explain:

1) ______
2) ______
3) ______
4) ______
5) ______

What are your hobbies/recreational activities and how often do you get to do them?

1) ______
2) ______
3) ______
4) ______
5) ______

**Nutritional / Lifestyle Information**

What beverages do you consume and how often?

How often do you eat fast food? Please elaborate on what kind it is and why you eat it.

How many meals per week do you consume that are homemade?
Do you enjoy cooking?

What changes/additions would you like to see in your life?

Please list any nutritional supplements you are taking, for how long, and what you understand them to be for:

1) ____________________________________________
2) ____________________________________________
3) ____________________________________________
4) ____________________________________________
5) ____________________________________________
6) ____________________________________________

## Sleeping Habits

| Hours of sleep per night: | Do you sleep in the same place every night? | Do you share your sleeping space?<br>Yes No Irregularly<br>If so with who? (i.e. spouse, child, pet) |
|---|---|---|

| Please describe your average night of sleeping (i.e. sound, irregular, dreams, etc.): |
|---|

## For Women

| Are you pregnant? Yes No Maybe | Last period: | Last PAP: |
|---|---|---|
| # of pregnancies: # of births: | # of miscarriages: | # of abortions: |
| Is your cycle regular? | Age of menarche: | Age of menopause: |
| If applicable, please tell me about your menstrual cycle: | | |

| Day | |
|---|---|
| Day 1 | |
| Day 2 | |
| Day 3 | |
| Day 4 | |
| Day 5 | |
| Day 6 | |

**For Women cont.**

If applicable, please tell me about your menopause (Beginning date, total duration, quality of beginning, middle, end):

If you have anything further to add, please do so here. Also, if you ran out of space in any segment you may utilize this space to continue.