Dr. Carlotta Watson
Holistic Health through Applied Kinesiology

Welcome to our clinic! Here's a checklist to help get you ready for your first visit.

___New patient paperwork filled out

___Bring all the supplements/medications that you are currently taking

___Women please wear pants (no skirts) to your visits

___Avoid wearing perfumes, essential oils, scented hair products, scented lotions

- The first visit will be approx *one hour 30 minutes*.

Intake Form

Name:____ Date:___________
Address:____
City:____________________ State:_____________ Zip:____________________
Telephone (home):___________________(work/cell):_______________________
Email address: ____
Age:______ Date of Birth: ________________________ Gender: Female / Male
__Married __Separated __Divorced __Widowed __Single __Partnership
Live with: __Spouse __Partner __Parents __Children __Friends __Alone
Occupation:_____________________________________ Hours per week:______
Employer:____
How did you hear about this clinic?______________________________________
Emergency contact:_____________________________Relationship:___________
Phone:____

Health History Questionnaire

What are your most important health problems? List in order of importance.

1)____
2)____
3)____
4)____
5)____
6)____

Family History

Do you have a family history of any of the following? (Please check)

☐ Cancer	☐ Stroke	☐ High blood pressure
☐ Kidney Disease	☐ Hay Fever	☐ Mental Illness
☐ Asthma	☐ Heart Disease	☐ Glaucoma
☐ Tuberculosis	☐ Arthritis	☐ Hypothyroidism
☐ Diabetes	☐ Anemia	☐ Depression/Anxiety
☐ Epilepsy	☐ Hives	☐ Alcoholism

Hospitalizations /Surgery /Accidents

What hospitalizations or surgeries have you had?
____year:______
____year:______
____year:______

List any accidents:
____year:______
____year:______
____year:______
List any broken bones and dislocations:
____

Were you ever knocked unconscious? Y N
Have you ever had a lapse of memory Y N

Patient Evaluation Questionnaire

1. Please rate on scale how serious you are about getting well (circle number).

0 1 2 3 4 5 6 7 8 9 10
Not Serious Very Serious

2. Would you prefer: (Please Circle).
A. Correction of Cause of Health Problems
B. Temporary Symptom Relief

3. Are you willing to follow a treatment program designed to help you return to health? (Treating the Cause)
A. Yes
B. No

4. Are you willing to take nutritional and/or homeopathic supplements?
A. Yes
B. No

5. Are you willing to make dietary changes?
A. Yes
B. No

6. Are you willing to start a moderate exercise program?
A. Yes
B. No

7. Please rate on scale how serious you are about staying healthy after your initial intensive care.

0 1 2 3 4 5 6 7 8 9 10
Not Serious Very Serious

8. Are you familiar with Applied Kinesiology?
A. Yes
B. No
C. Very little (somewhat)

9. Have you ever been treated by a Chiropractor or Naturopath?
A. Yes
B. No
If yes, how were your results?____

10. Please rate your stress on scale.

0 1 2 3 4 5 6 7 8 9 10
No Stress Total Stress

11. Are any doctors or practitioners currently treating you?
A. Yes
B. No

If yes, please list____
____
____

Toxic Profession Past or Present
(Artist, graphic designer, dental asst, gas station worker, painter, industry, cleaners, etc.)
____ Age:___________
____Age:___________
____Age:___________

Major Psychological Trauma
____ Age:___________
____Age: ___________
____Age: __________

Serious Infections/Diseases
(pneumonia, mono, TB, cancer, heart attack, stroke, hepatits, etc)
____ Age: __________
____Age: __________
____Age: __________

Long periods on prescriptions or street drugs
____Age:__________
____Age: __________
____Age: __________

Long visits or lived in a foreign country like India, Mexico, Africa, etc.
____Age:__________
__________________________________ ___________Age: __________
____Age: __________
Treated for parasites, infection? Y N

Allergies

Are you hypersensitive or allergic to…
Any drugs? ____
Any foods? ____
Any environmentals? ____________________________________

Current Medications

- ☐ Laxatives
- ☐ Cortisone
- ☐ Tranquilizers
- ☐ Pain relievers
- ☐ Appetite suppressants
- ☐ Thyroid medication
- ☐ Birth control pills
- ☐ Antacids
- ☐ Sleeping Pills
- ☐ Antibiotics

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

____
____
____

Typical Food Intake

Breakfast:____
Lunch:____
Dinner____
Snacks:____
Drinks:____

Habits

Main interests and hobbies____
____
Do you exercise? Y N
If yes, what kind? ______________________ How often? ______________________
Average 7-8 hrs sleep? Y N
Sleep Well? Y N
Awaken rested? Y N
When during the day is your energy the best? __________ Worst? __________________
Have a supportive Relationship Y N
Have a history of Abuse? Y P N
Use Recreational drugs? Y P N
Do you eat three meals a day? Y N
Do you eat out often? Y N
Do you drink coffee? Y N
Do you drink black/green/herbal teas? Y N
Enjoy your work? Y N
Take vacations? Y N
Spend time outside? Y N
Watch television? Y N How many hours? ________
Alcoholic beverages Y P N How many per week?_______
Smoke? Y P N How much per day?______ How many years?____
Do you have a religious or spiritual practice? Y N
If yes, what?____

How does your condition affect you? ______________________________________
____
____
____
What do you think is happening?____
____
____
____
Why?____
____
____
____
What do you feel needs to happen for you to get better?_______________________
____
____
____
How long do you think it will take for you to get better?_______________________
____
____

Review of symptoms

Y= a condition you have now **N**= never had **P**= a condition you have had before

Have you had, or do you have any of the following conditions:

Condition		Condition	
Appendicitis	Y P N	Chicken Pox	Y P N
Polio	Y P N	Alcoholism	Y P N
Whooping cough	Y P N	Epilepsy	Y P N
Anemia	Y P N	HIV	Y P N
Measles	Y P N	Multiple Sclerosis	Y P N
Mumps	Y P N		

General

Condition		Condition	
Chills	Y P N	Loss of Sleep	Y P N
Convulsions	Y P N	Loss of Weight	Y P N
Fainting	Y P N	Neuralgia	Y P N
Fatigue	Y P N	Sweats	Y P N
Fever	Y P N		

Mental/Emotional

Condition		Condition	
Treated for emotional problems	Y P N	Depression	Y P N
Mood swings	Y P N	Anxiety or nervousness	Y P N
Considered/Attempted suicide	Y P N	Tension	Y P N
Poor concentration	Y P N	Memory problems	Y P N

Endocrine

Condition		Condition	
Hypothyroid	Y P N	Diabetes	Y P N
Hypoglycemia	Y P N	Excessive hunger	Y P N
Excessive thirst	Y P N	Seasonal depression	Y P N
Fatigue	Y P N	Night sweats	Y P N
Heat or Cold intolerance	Y P N		

Immune

Condition		Condition	
Chronic fatigue Syndrome	Y P N	Reactions to vaccinations	Y P N
Chronic swollen glands	Y P N	Chronic infections	Y P N
		Slow wound healing	Y P N

Neurologic

Condition		Condition	
Seizures	Y P N	Numbness or tingling	Y P N
Muscle weakness	Y P N	Easily stressed	Y P N
Loss of Memory	Y P N	Loss of Balance	Y P N
Vertigo or dizziness	Y P N	Fainting	Y P N
Paralysis	Y P N		

Skin

Rashes	Y P N	Lumps	Y P N
Eczema or Hives	Y P N	Itching	Y P N
Acne/Boils	Y P N	Hair loss	Y P N
Color change	Y P N	Bruises easily	Y P N

Head Eyes Ears Nose Throat

Headaches	Y P N	Frequent colds	Y P N
Migraines	Y P N	Stuffy nose	Y P N
Head injury	Y P N	Runny nose	Y P N
Jaw/TMJ problems	Y P N	Sinus problems	Y P N
Spots in Eyes	Y P N	Nose bleeds	Y P N
Impaired vision	Y P N	Hay fever	Y P N
Blurriness	Y P N	Loss of Smell	Y P N
Colorblindness	Y P N	Frequent sore throat	Y P N
Double vision	Y P N	Teeth grinding	Y P N
Cataracts	Y P N	Gum problems	Y P N
Glasses or contacts	Y P N	Dental Cavities	Y P N
Eye pain/strain	Y P N	Sores on tongue or	Y P N
Tearing or dryness	Y P N	lips	Y P N
Glaucoma	Y P N	Hoarseness	Y P N
Impaired hearing	Y P N	Difficulty Swallowing	Y P N
Earaches	Y P N	Goiter	Y P N
Ringing	Y P N	Swollen glands	Y P N
Dizziness	Y P N		

Respiratory

Cough	Y P N	Shortness of breath	Y P N
Persistent Cough	Y P N	Shortness of breath at night	Y P N
Spitting up blood	Y P N	Tuberculosis	Y P N
Asthma	Y P N	Spitting up phlegm	Y P N
Pneumonia	Y P N	Wheezing	Y P N
Emphysema	Y P N	Bronchitis	Y P N
Pain on breathing	Y P N		

Cardiovascular

Heart disease	Y P N	Varicose veins	Y P N
High blood pressure	Y P N	Murmurs	Y P N
Low blood pressure	Y P N	Blood clots	Y P N
Pain over heart	Y P N	Phlebitis	Y P N
Poor circulation	Y P N	Rheumatic fever	Y P N
Rapid heart	Y P N	Swelling in ankles	Y P N
Slow heart	Y P N	Palpitations/fluttering	Y P N
Stroke	Y P N		

Gastrointestinal

Trouble swallowing	Y P N	Heart burn	Y P N
Change in thirst	Y P N	Change in appetite	Y P N
Nausea	Y P N	Constipation	Y P N
Vomiting blood	Y P N	Diarrhea	Y P N
Blood in stool	Y P N	Gallbladder trouble	Y P N
Abdominal pain/cramps	Y P N	Ulcer	Y P N
Belching or passing gas	Y P N	Hemorrhoids	Y P N
Black stools	Y P N	Poor appetite	Y P N
Liver trouble	Y P N	Poor digestion	Y P N

Bowel movements: How often?________ Is this a change?_______

Urinary

Pain on urination	Y P N	Kidney stones	Y P N
Frequency at night	Y P N	Blood in urine	Y P N
Frequent infections	Y P N	Kidney infection	Y P N
Increased frequency	Y P N	Prostate trouble	Y P N
Inability to hold urine	Y P N		

Male reproduction

Hernias	Y P N	Premature ejaculation	Y P N
Testicular pain	Y P N	Testicular masses	Y P N
Venereal disease	Y P N	Prostate disease	Y P N
Impotence	Y P N	Discharge or sores	Y P N

Female Reproduction/Breasts

Age of first menses________		Discharge	Y P N
Age of last menses________		Herpes	Y P N
Length of cycle_______days		Venereal Disease	Y P N
Duration of menses_____days		IUD	Y P N
Painful menses	Y P N	Birth control?	Y P N
Heavy or excessive flow	Y P N	What type?________________	
PMS	Y P N	Number of pregnancies________	
If yes, what are your symptoms?___________		Number of live births________	
Endometriosis	Y P N	Number of miscarriages_______	
Ovarian cysts	Y P N	Number of abortions_________	
Difficult conceiving	Y P N	Hot flashes	Y P N
Are cycles regular	Y P N	Lump in breast	Y P N
Bleeding between cycles	Y P N	Have you had a mammogram?	Y N
Pain during intercourse	Y P N	Last Pap smear date?____________	
Clotting	Y P N	Was it normal?	Y N

Muscles/Joints/Bones

Backache	Y P N	Stiff neck	Y P N
Foot trouble	Y P N	Swollen Joints	Y P N
Pain between	Y P N	Tremors/Twitching	Y P N
shoulders	Y P N	Arm Trouble	Y P N
Painful tail bone	Y P N		

If you have musculoskeletal pain, please complete the following:

Please mark the intensity of your pain today: 0 = no pain, 10= intense pain.

Area:____ Intensity:_________
Area:____ Intensity:_________
Area:____ Intensity:_________
Area:____ Intensity:_________

How long has this condition lasted?_________________________________
Is this condition: ___Getting worse ___The Same ___Improving
Was this caused by an injury/accident? Y N
If no, when did you first notice it?____

Pain came on: ___Gradually ___Suddenly
The pain is: ___Occasional ___Frequent ___Constant
Describe the pain: ___Sharp (knife-like) ___Dull (toothache) ___Burning (hot)
Does the pain: ___Stay in one spot ___Radiate (shoots) ___Go up &down spine
What time of day is the pain worst: ___Morning __Afternoon __Evening __Night ___All the time
Do you have pain in: __Legs __Feet __Arms __Hands __Left __Right
Numbness or tingling in: __Legs __Feet __Arms __Hands __Left __Right
What makes the pain worse?____
What makes the pain better?____
Does the pain affect your sleeping: __No __Occasionally __Frequently __Constantly
Does your pain affect your work? __No __Occasionally __Frequently __Constantly
Have you been hospitalized in the last five years?
If yes, for what?____
Have you had major surgery in the last five years?
If yes, for what? ____
Have you seen other doctors for this condition? Y N
If yes, doctor's name:____