Whole Health and Wellness
599 Main St
Malden, MA 02148
(781) 324-2330

Welcome to the
Whole Health and Wellness Office
of Dr. Mary Medwar!

In order to better serve you, please fill out the following attached forms *thoroughly and completely. Please bring completed paperwork to your appointment. Failure to do so will result in a rescheduled appointment and you will be charged a $75.00 rescheduling fee.*

- ☐ New Patient Information Forms (3 pages)
- ☐ Dietary Intake Form (starting 2 days prior to initial appointment) (1 page)
- ☐ Systems Survey Forms (4 pages)

On the day of your initial appointment, for accurate results please…

- ☐ Please be hydrated, drink plenty of water several days in advance of your appointment
- ☐ Please do not consume excessive sugar 2 hours prior to your appointment
- ☐ Please do not consume caffeine 2 hours prior to your appointment
- ☐ Please wear a plain, light colored shirt without a color print or wording (pastel colors are ok if you do not own a plain white shirt)
- ☐ Please bring all of your prescription medications with you (in their original bottles)
- ☐ Please bring in any supplements/vitamins you may be currently taking with you (in their original bottles)

YOUR INITIAL APPOINTMENT IS ON: _____ for 60-75 minutes
Please arrive 15 minutes early to confirm paperwork/information and have a Heart Rate Variability test.

YOUR REPORT OF FINDINGS APPOINTMENT IS ON: _____ for 1 hour
Please bring any family/spouse/significant other(s) who may cook or grocery shop for you to this appointment.

We Look Forward to Meeting You!!!
New Patient Information Form – pg 1
PLEASE PRINT CLEARLY

Name:_____ **Date**:_____

First *Middle* *Last*

Nickname:_____

Physical Address:_____

City: _____ **State**: _____ **Zip**: _____

Mailing Address (if different): _____

City: _____ **State**: _____ **Zip**: _____

Cell #: _____ **Home #**:_____ **Work #**: _____

Cell Phone Provider:_____

Email Address: _____

Emergency Contact: _____ **Relationship**:_____

Phone #1:_____ **Phone #2**: _____

Who/How were you referred to us?:_____

Employment Status:_____

Occupation:_____ **Employer**:_____

Date of Birth: _____ **Age**: _____ **Sex**:_____ **Height**:_____ **Weight**:_____

Social Security #_____**Credit Card #**_____**Exp date**_____

How would you rank your overall health (Circle One)? Excellent / Fair / Poor / Other:_____

What is your chief complaint(s)/reason(s) you are here? (Feel free to continue on the back of this sheet if needed):

_____

_____

_____

_____

Have you received treatment for above complaint(s)? _____

If yes, please provide details/specifics: _____

_____

_____

_____

New Patient Information Form – pg 2

PLEASE PRINT CLEARLY

Please list all current pharmaceutical medications you are taking with their dosage information:

□ I'm not currently taking any medications

1.) _____ 5.)_____

2.) _____ 6.) _____

3.) _____ 7.) _____

4.) _____ 8.) _____

Are you currently under the care of a Primary Care Physician? □ yes □ no

If so, what is their name? _____ City/State (of Office Location):_____

Are you currently under the care of a Chiropractor? □ yes □ no

If so, what is their name? _____ City/State (of Office Location):_____

Please list any Nutritional Supplements/Vitamins you are taking and their dosages:

1.) _____ 5.)_____

2.) _____ 6.) _____

3.) _____ 7.) _____

4.) _____ 8.) _____

Tobacco use: □ Current daily smoker (# of cigarettes per day_____) □ Former smoker □Never a smoker

Smoking start date: _____smoking quit date:_____

Interest in quitting: 0 - 1 - 2 - 3 - 4 - 5 - 6 -7 - 8 - 9 -10 (0 = no interest, 10 = extremely interested)

Caffeine intake: □ I do not have caffeine □Socially only □ 1-2 per day (8 oz) □ 3 or more per day (8 oz)

Alcohol use: □ I do not use alcohol □ Socially □ 1-2 per day (8 oz) □ 3 or more per day (8 oz)

Have you been diagnosed with: □ High Blood Pressure □ Asthma □ Diabetes (□ type I □ type II)

Please list any major illnesses you have had with an approximate date of onset:

1.) _____ 5.)_____

2.) _____ 6.) _____

3.) _____ 7.) _____

4.)_____ 8.)_____

New Patient Information Form – pg 3

PLEASE PRINT CLEARLY

Please list any accidents, injuries, or surgeries you have had with an approximate date of onset:

1.) _____ 4.)_____

2.) _____ 5.) _____

3.) _____ 6.) _____

Please list any children (including any non-biological children) under your care:

Name:	Age:	Sex:	Any health/physical conditions/concerns?
1.)_____	____	____	_____
2.) _____	____	____	_____
3.) _____	____	____	_____
4.) _____	____	____	_____

Is there any history of serious illness in your family? Circle any that apply.

Cancer / Type I Diabetes / Type II Diabetes / Heart Disease / Stroke / Other:

Please list types of cancer:

1.) _____

2.) _____

3.) _____

Please list any others:

1.) _____

2.) _____

3.) _____

Please list the type of household pets or animals you are regularly in contact with:

1.) _____ 2.) _____ 3.) _____

Is there anything we can help you with to make you happier? _____

_____

I have filled out and answered the above information to the best of my ability.

SIGNED: _____ **DATE:** _____

Office Use Only

Height:	Weight:	BMI:	BP:	Pulse:

Dietary Intake Form

PLEASE PRINT CLEARLY

Please list the foods & drinks you have consumed starting 2 days prior to your initial appointment in our office:

DAY ONE:

Breakfast: _____

_____

_____

_____

_____

Snack: _____

_____

_____

Lunch: _____

_____

_____

_____

_____

Snack: _____

_____

_____

Dinner: _____

_____

_____

_____

_____

Snack: _____

_____

_____

Amount of plain water consumed today in ounces:

_____

DAY TWO:

Breakfast:_____

_____

_____

_____

_____

Snack: _____

_____

_____

Lunch: _____

_____

_____

_____

_____

Snack: _____

_____

_____

Dinner: _____

_____

_____

_____

_____

Snack: _____

_____

_____

Amount of plain water consumed today in ounces:

_____

System Surveys Form – pg 1

Instructions: Circle the number that applies to you. If a symptom does not apply, leave it blank.

Circle either: (1) = MILD symptoms (occurs rarely)
(2) = MODERATE symptoms (occurs several times a month)
(3) = SEVERE symptoms (occurs almost constantly)

GROUP ONE:

1 2 3 Acidic food upset
1 2 3 Get chilled often
1 2 3 "Lump" in throat
1 2 3 Dry mouth/eyes/nose
1 2 3 Pulse speeds after meal
1 2 3 Keyed up – fail to calm
1 2 3 Cuts heal slowly
1 2 3 Gag easily
1 2 3 Unable to relax, startles easily
1 2 3 Extremities cold, clammy
1 2 3 Strong light irritates
1 2 3 Urine amount reduced
1 2 3 Heart pounds after retiring
1 2 3 "Nervous" stomach
1 2 3 Appetite reduced
1 2 3 Cold sweats often
1 2 3 Fever easily raised
1 2 3 Neuralgia like pains
1 2 3 Staring, blinks little
1 2 3 Sour stomach frequent

GROUP TWO:

1 2 3 Joint stiffness after arising
1 2 3 Muscle-leg-toe cramps at night
1 2 3 "Butterfly" stomach, cramps
1 2 3 Eyes or nose watery
1 2 3 Eyes blink often
1 2 3 Eyelids swollen, puffy
1 2 3 Indigestion soon after meals
1 2 3 Always seem hungry, Feels lightheaded often
1 2 3 Digestion rapid
1 2 3 Vomiting frequent
1 2 3 Hoarseness frequent
1 2 3 Breathing irregular
1 2 3 Pulse slow, feels irregular
1 2 3 Gagging reflex slow
1 2 3 Difficulty swallowing
1 2 3 Constipation, diarrhea alternating
1 2 3 "Slow starter"
1 2 3 Get "chilled" frequently
1 2 3 Perspire easily
1 2 3 Circulation poor, sensitive to cold
1 2 3 Subject to colds, asthma, bronchitis

GROUP THREE:

1 2 3 Eat when nervous
1 2 3 Excessive appetite
1 2 3 Hungry between meals
1 2 3 Irritable before meals
1 2 3 Get shaky if hungry
1 2 3 Fatigue, eating relieves
1 2 3 Lightheaded if meals delayed
1 2 3 Heart palpitates if meals missed or delayed
1 2 3 Afternoon headaches
1 2 3 Overeating sweets upsets
1 2 3 Awaken after few hours sleep hard to get back to sleep
1 2 3 Crave candy or coffee in afternoons
1 2 3 Moods of depression – "blues" or melancholy
1 2 3 Abnormal craving for sweets or snacks

GROUP FOUR:

1 2 3 Hands and feet go to sleep easily, numbness
1 2 3 Sigh frequently, "air hunger"
1 2 3 Aware of breathing heavily
1 2 3 High altitude discomfort
1 2 3 Opens windows in closed room
1 2 3 Susceptible to colds and fevers
1 2 3 Get drowsy often
1 2 3 Swollen ankles worse at night
1 2 3 Muscle cramps, worse during exercise
1 2 3 Shortness of breath on exertion
1 2 3 Dull pain in chest or radiating into left arm, worse on exertion
1 2 3 Bruise easily, black and blue spots
1 2 3 Tendency to anemia
1 2 3 Nose bleeds frequent
1 2 3 Noises in head or ringing in ears
1 2 3 Tension under breastbone, or feeling of tightness, worse on exertion

System Surveys Form – pg 2

Instructions: Circle the number that applies to you. If a symptom does not apply, leave it blank.

Circle either: (1) = MILD symptoms (occurs rarely)
(2) = MODERATE symptoms (occurs several times a month)
(3) = SEVERE symptoms (occurs almost constantly)

GROUP FIVE:

1 2 3 Dizziness
1 2 3 Dry skin
1 2 3 Burning feet
1 2 3 Blurred vision
1 2 3 Itching skin and feet
1 2 3 Excessive falling hair
1 2 3 Frequent skin rashes
1 2 3 Bitter, metallic taste in mouth in mornings
1 2 3 Bowel movements painful or difficult
1 2 3 Worrier, feels insecure
1 2 3 Feeling queasy; headache over eyes
1 2 3 Greasy foods upset
1 2 3 Stools light-colored
1 2 3 Skin peels on foot soles
1 2 3 Pain between shoulder blades
1 2 3 Use laxatives
1 2 3 Stools alternate from soft to watery
1 2 3 History of gallbladder attacks or gallstones
1 2 3 Sneezing attacks
1 2 3 Dreaming, nightmare type bad dreams
1 2 3 Bad breath
1 2 3 Milk products cause distress
1 2 3 Sensitive to hot weather
1 2 3 Burning or itching
1 2 3 Crave sweets

GROUP SIX:

1 2 3 Loss of taste for meat
1 2 3 Lower bowel gas several hours after eating
1 2 3 Burning stomach sensations, eating relieves
1 2 3 Coated tongue
1 2 3 Pass large amounts of foul-smelling gas
1 2 3 Indigestion 30-60 minutes after eating
1 2 3 Mucous colitis or "irritable bowel"
1 2 3 Gas shortly after eating
1 2 3 Stomach bloating after eating

GROUP SEVEN:

(A)

1 2 3 Insomnia
1 2 3 Intolerance to heat
1 2 3 Night sweats
1 2 3 Heart palpitates
1 2 3 Eyelids and face twitch
1 2 3 Can't work under pressure
1 2 3 Nervousness
1 2 3 Highly emotional
1 2 3 Thin, moist skin
1 2 3 Increase appetite without weight gain
1 2 3 Can't gain weight
1 2 3 Flush easily
1 2 3 Inward trembling
1 2 3 Pulse fast at rest
1 2 3 Irritable and restless

(B)

1 2 3 Increase in weight
1 2 3 Ringing in ears
1 2 3 Dry or scaly skin
1 2 3 Hair course, falls out
1 2 3 Frequency of urination
1 2 3 Reduced initiative
1 2 3 Decrease in weight
1 2 3 Sleepy during the day
1 2 3 Constipation
1 2 3 Headaches upon arising wear off during the day
1 2 3 Fatigue easily
1 2 3 Sensitive to cold
1 2 3 Mental sluggishness
1 2 3 Slow pulse, below 55
1 2 3 Impaired hearing

System Surveys Form – pg 3

Instructions: Circle the number that applies to you. If a symptom does not apply, leave it blank.

Circle either: (1) = MILD symptoms (occurs rarely)
(2) = MODERATE symptoms (occurs several times a month)
(3) = SEVERE symptoms (occurs almost constantly)

(C)

1 2 3 Failing memory
1 2 3 Headaches, splitting or Rendering type
1 2 3 Low blood pressure
1 2 3 Decreased sugar tolerance
1 2 3 Increased sex drive

(D)

1 2 3 Abnormal thirst
1 2 3 Sex drive reduced or lacking
1 2 3 Increased sugar tolerance
1 2 3 Bloating of abdomen
1 2 3 Tendency to ulcers, colitis
1 2 3 WOMEN: menstrual disorders
1 2 3 Weight gain around hips or waist
1 2 3 YOUNG GIRLS: lack of menstruation

(E)

1 2 3 Dizziness
1 2 3 Increased blood pressure
1 2 3 FEMALES: Masculine tendencies
1 2 3 Headaches
1 2 3 FEMALES: Hair growth on face or body
1 2 3 Hot flashes
1 2 3 Sugar in urine (not diabetes)

(F)

1 2 3 Weakness, dizziness
1 2 3 Nails weak or ridged
1 2 3 Perspiration increase
1 2 3 Swollen ankles
1 2 3 Allergies – tendency to asthma
1 2 3 Respiratory disorders
1 2 3 Chronic fatigue
1 2 3 Tendency to hives
1 2 3 Bowel disorders
1 2 3 Crave salt
1 2 3 Weakness after colds, influenza
1 2 3 Low blood sugar
1 2 3 Arthritic tendencies
1 2 3 Poor circulation
1 2 3 Brown spots or bronzing of skin
1 2 3 Exhaustion – muscular and nervous

GROUP EIGHT:

1 2 3 Muscle weakness
1 2 3 Muscular soreness
1 2 3 Hyper irritable
1 2 3 Swelling of ankles
1 2 3 Tendency to consume sweets or carbohydrates
1 2 3 Night sweats
1 2 3 Redness of palms of hands and bottom of feet
1 2 3 Nervousness causing loss of appetite
1 2 3 Forgetfulness
1 2 3 Lack of stamina
1 2 3 Rapid heartbeat
1 2 3 Feeling of band around head
1 2 3 Diminished urination
1 2 3 Muscle spasms
1 2 3 Loss of muscular control
1 2 3 Rapid digestion
1 2 3 Visible veins on chest and abdomen
1 2 3 Nervousness with indigestion
1 2 3 Gastritis
1 2 3 Thinning hair
1 2 3 Drowsiness after eating
1 2 3 Melancholia (feeling of sadness)
1 2 3 Blurred vision
1 2 3 Numbness
1 2 3 Sensitivity to noise
1 2 3 Hemorrhoids
1 2 3 Apprehension (feeling that something bad is going to happen)

System Surveys Form – pg 4

Instructions: Circle the number that applies to you. If a symptom does not apply, leave it blank.

Circle either: (1) = MILD symptoms (occurs rarely)
(2) = MODERATE symptoms (occurs several times a month)
(3) = SEVERE symptoms (occurs almost constantly)

FEMALE ONLY:

1 2 3 Very easily fatigued
1 2 3 Depressed feelings before menstruation
1 2 3 Vaginal discharge
1 2 3 Menopausal hot flashes
1 2 3 Acne worse at menses
1 2 3 Premenstrual tension
1 2 3 Menstruation excessive and prolonged
1 2 3 Hysterectomy/ovaries removed
1 2 3 Depression of long standing
1 2 3 Painful menses
1 2 3 Painful breasts
1 2 3 Menstruate too frequently
1 2 3 Menses scanty or missed

MALE ONLY:

1 2 3 Prostate trouble
1 2 3 Depression
1 2 3 Feeling of incomplete bowel evacuation
1 2 3 Avoids activity
1 2 3 Urination difficult or dribbling
1 2 3 Pain on inside of legs or heels
1 2 3 Lack of energy
1 2 3 Tire too easily
1 2 3 Leg nervousness at night
1 2 3 Night urination frequent
1 2 3 Migrating aches and pains
1 2 3 Diminished sex drive