



CHERYL LEUTHAEUSER, D.O  
 4003 Broadview Rd.  
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[www.integrativewellcare.com](http://www.integrativewellcare.com)

Main 330-659-2320  
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[drcheryl@integrativewellcare.com](mailto:drcheryl@integrativewellcare.com)

**PERSONAL INFORMATION**

Date Questionnaire Received      /      /      Date of Initial Consultation      /      /					
<b>Above line is for office use only.</b>					
Patient Name: First		Last		Middle Initial	
Address: Street			City		
State		Zip code		Home Phone (      )	
Work Phone (      )			Cell Phone (      )		
Email address			Fax (      )		
Age	Birth Date: Month		Day	Year	Sex (Circle One) Female/Male
Social Security Number (optional)					
Place of Birth			Race/National/Ethnic Roots		
Height	Weight	lbs.	Circle One: Right-handed / Left-handed / Mixed Dominance		
Occupation					
<b>HEALTH INSURANCE INFORMATION</b>					
*Please note → We do not accept any health insurance. You are responsible for submitting your own claims.*					
Primary Health Insurance			ID/Group #		
Secondary Health Insurance					
<b>OTHER</b>					
Primary Care Physician			Phone		
City, State			Fax		
Your local Pharmacy			Phone		
City, State			Fax		
<b>GENERAL</b>					
Referred by					
What brings you to our office today?					
What do you hope to get from today's visit?					



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**MEDICAL HISTORY**

**PRIMARY DOCTOR (S)**

Name	Phone Numbers	City, State	Last Visit

**SPECIALISTS**

Name	Specialty	Phone Numbers	City, State	Last Visit

**NUTRITIONIST**

Name	Phone Numbers	City, State	Last Visit

**NATUROPATH (S) and/or HOMEOPATH (S)**

Name	Phone Numbers	City, State	Last Visit

**THERAPIST (S)**

Name	Type of Therapist	Phone Numbers	City, State	Last Visit

**OTHER**

Name	Phone Numbers	City, State	Last Visit



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## CURRENT HEALTH CONCERNS

What are your major CURRENT health problems?

Problem and Brief Description	Date of Onset	Frequency (daily, weekly...)	Severity (mild, mod or severe)

How much time have you lost from work or school in the past year?

Why?

--



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**PAST MEDICAL HISTORY**

*\*Include any chronic/recurring disorder or previously treated problems/diseases which no longer affect you.\**  
 Examples of chronic/recurring disorders – Recurrent Fungal Infections, Diabetes Mellitus, Chronic Fatigue, etc.  
 Examples of treated problems that no longer affect you – Tuberculosis, Meningitis, etc.

Condition	Past Treatments	Current Treatments	Approximate Date (s) of Treatment

Do you have a history of Learning Problems? \_\_\_\_\_ If yes, please provide details (including how they were addressed)

Provide details of any tattoos or body piercings you may have?





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## OTHER MEDICATIONS AND SUPPLEMENTS

Please list any other medications you have **TAKEN IN THE PAST?** Specifically indicate any frequent use of antibiotics and/or steroids. Also, please comment as to whether you had good, bad or no response to each medication

Current medications.

Previous supplements.

Current supplements.

Have you ever used CHELATING AGENTS? If yes, please specify name, dose, route, frequency of use, reason for use, and approximate dates of starting and stopping treatment.



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**HEALTH MAINTENANCE UPDATE**

Test	Date	Results
Physical Examination		
Eye Exam		
Dental Exam		
Breast Exam		
Digital Rectal Exam		
Stool Occult Blood		
Cholesterol Profile		
Bone Density (DEXA) Scan		
Mammogram		
PSA		
Colonoscopy or Flexible Sigmoidoscopy		
PAP Test		
Cardiac Stress Test (Specify Type)		
Hearing Test		

**SURGICAL HISTORY**

Chronologically list major/minor surgeries you have had or are planning – include approximate dates and complications.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Any major accidents or injuries? Please describe.




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## FEMALE HEALTH HISTORY

Age at first period _____ Date of last period _____ Length of cycles _____
History of irregular/abnormal periods? ____ Yes ____ No If yes, please describe
Please check if you have a history of ____ Endometriosis ____ Fibroids ____ Polycystic Ovarian Syndrome?
Describe any premenstrual symptoms
Do you have a history of abnormal PAP tests? _____ If yes, please describe
Are you taking birth control pills? ____ If yes, for how long? ____ If no, have you ever taken them? _____
Any known history of Infertility problems? _____ If yes, please explain
Pregnancies: None _____ Term Births _____ Miscarriages _____ Abortion _____
Preemies _____ Birth weight of largest baby _____ Smallest baby _____
Are you currently pregnant? _____ If so, what is your due date? _____
If you have never been pregnant, do you wish to have children in the future? _____
If you have children, do you plan to have more? _____
Illnesses or complications during pregnancy or labor and delivery
Medications taken during pregnancy or labor and delivery
If you have ever had a C-Section, please explain
Any complications for you after delivery?
Did you (or do you plan to) breast feed your children? _____
Do you take any prescription medications or natural substances for peri- or post-menopausal symptoms? _____
If yes, provide names, dosages, etc?
Any history of breast problems (tenderness, cysts, etc.)?
Any history of yeast infections? If yes, please explain



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## EARLY HEALTH HISTORY

Did your mother have any known problems during her pregnancy with you (illness, stress, medications, smoking, vaccines, alcohol)?

--	--

Were you breastfed or bottle-fed? If breastfed, please indicate duration

--	--

Did you have any significant stresses in childhood or adolescence? If yes, please explain

--	--

Please check if you had any of the following childhood illnesses?

Frequent Ear, Throat or other Infections  
  Colic  
  Reflux  
  Meningitis  
  Thrush  
 Asthma  
  Chicken Pox  
  Eczema  
  Frequent Colds  
  Other \_\_\_\_\_

Did you take \_\_\_\_\_ antibiotics or \_\_\_\_\_ steroid medications frequently?

Did you ever have adverse reactions to vaccines? If yes, explain

Did you have a problem with bed-wetting? Until what age? \_\_\_\_\_

## FAMILY HISTORY

List any allergies, major illnesses, genetic diseases or problems (such as digestive issues or mental health problems) for each family member. \*\*If any family members are deceased, please also list their age at death and cause.

Mother	
Father	
Siblings	
Maternal Grandparents	
Paternal Grandparents	
Others	

Are you or anyone in your family ADOPTED? \_\_\_\_\_ If yes, please specify who

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## DIETARY/NUTRITIONAL/DIGESTIVE HISTORY

Are you currently following a special diet? Please explain

Have you tried \_\_\_ Gluten Free \_\_\_ Casein Free \_\_\_ Yeast Free \_\_\_ Salicylate Free \_\_\_ Atkins  
 \_\_\_ South Beach \_\_\_ Low Phenols \_\_\_ IgG reactive food avoidance \_\_\_ Specific Carbohydrate Diet  
 \_\_\_ Low Protein \_\_\_ Other \_\_\_\_\_

Your diet → % for the following: \_\_\_ Organic/Fresh Food \_\_\_ Processed Food \_\_\_ Fast Food \_\_\_ Other

Known food allergies

Suspected food SENSITIVITIES

Food CRAVINGS (e.g. bread, pasta, cheese, salty foods, sodas/coffee/tea with or without caffeine, alcohol, milk, etc.)

### FOODS YOU EAT – Place a √ in the appropriate column

Food	Daily	> Once per Week	Rarely	Never	Used to Eat
Cookies					
Candy					
Sweets in general					
Caffeine (soda, tea, coffee)					
Milk – Specify Type (e.g. cow’s, rice, soy, etc. and whole, 2%, 1% or skim)					
Cheese					
Ice Cream					
Salty Foods					
Meat					
Pasta					
Bread – Specify Type					
Vegetables					
Fruits					
Fried Foods					
Grains					

Describe your stool pattern (frequency, color, odor, consistency)

Do you or have you ever had gastrointestinal problems? Please describe



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## ENVIRONMENTAL/ALLERGY HISTORY

LOCATION    ___ City    ___ Suburban    ___ Wooded    ___ Farm    ___ Other _____
WATER    ___ City    ___ Well    If you have a purification system, please describe _____
Type of HEAT    ___ Electric    ___ Gas    ___ Oil    ___ Other _____
Do you live near ___ Power lines ___ Woods ___ Industrial areas ___ Water → Type (ocean, swamp, etc.) _____
Does your home have a lot of    ___ Dust    ___ Mold    ___ Down/Feather items (pillows, stuffed animals, etc.)
Are there specific areas in your home that you suspect have issues? Please describe
Bedding    ___ Synthetic    ___ Down    ___ Feather    ___ Mattress cover
Flooring    ___ Wall-to-Wall Carpet    ___ Area rug    ___ Wood    ___ Glued down    ___ Synthetic Pad
Window Treatment    ___ Shades    ___ Blinds    ___ Thin curtain    ___ Valence    ___ Other _____
What is your occupation?
Have you had any known exposure to harmful chemicals?
List any pets you have in that home
Do you have any known ALLERGIES to food and/or medications? If yes, please list names and describe reactions.
Are you sensitive to any of the following? Check where appropriate.
_____ Perfumes/Cosmetics    _____ Cleaning Products    _____ Mold    _____ Paint _____ Pollens/Grasses    _____ Soaps    _____ Animals (dander) _____ Detergents    _____ Dust    _____ Gasoline    _____ Tobacco Smoke _____ Other, Please describe _____
Are there foods that you avoid because of how they make you feel? Please explain.



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## SIGNS AND SYMPTOMS

Please check where appropriate. Leave row blank if not applicable

Current	Past	Description	Mild	Mod	Severe	Details
		Fatigue				
		Difficulty falling asleep				
		Difficulty staying asleep				
		Daytime sleepiness				
		Heat intolerance				
		Cold intolerance				
		Flushing				
		Headache – Specify Type				
		Low self esteem				
		Trouble remembering				
		Seizures				
		Anxiety				
		Depression				
		Panic attacks				
		Suicidal thoughts				
		Fainting				
		Difficulty with concentration				
		Sore throat				
		Congestion				
		Dark circles/puffiness under eyes				
		Sinus infections				
		Post nasal drip				
		Bad breath				
		Cough				
		Wheezing				
		Seasonal allergies				
		Palpitations				
		Varicose veins				



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**SIGNS AND SYMPTOMS CONTINUED**

	Heart attack				
	TMJ problems				
	Muscle weakness				
	Muscle stiffness				
	Joint stiffness				
	Joint pain				
	Cold sores				
	Cracking at corner of lips				
	Nausea				
	Vomiting				
	Abdominal pain				
	Bloating				
	Belching				
	Diarrhea				
	Constipation				
	Blood in stool				
	Hemorrhoids				
	Eczema				
	Hives				
	Rash				
	Sensitive to bug bites				
	Kidney stones				
	Psoriasis				
	Reflux				
	Other				
	Other				
	Other				
	Other				

Do you have any dental amalgams (silver fillings)? If so, how many? \_\_\_\_\_

Any history of dental problems?

Any plans for special dental procedures in the future?

