

Vue Wellness Center  
Truly Holistic Health  
(425) 516-5500

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, and scented lotions

The first visit will be approx one hour 30 minutes. Please arrive 10 minutes before your scheduled time. There is parking below the Skyline Tower that can be entered on 110th Ave, just South of 4th Ave.. We are just one block from the Bellevue Transit Center and across the street from the Bellevue City Hall. The Bellevue Square Mall is only 5 blocks away.

**Vue**  
**Wellness**

**Dr. Barry Wheeler, ND**  
Vue Wellness Center

Address:  
Skyline Tower  
10900 Northeast 4th Street  
Suite 2300  
Bellevue, WA 98004

**Phone: (425) 516-5500**  
Hours: 8am - 5pm, Monday - Friday

**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)

<input type="checkbox"/> Cancer	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hives
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> 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

<----->

Not Serious <-> Very Serious

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, hepatitis, 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 environmental? \_\_\_\_\_

**Current Medications**

<input type="checkbox"/> Laxatives	<input type="checkbox"/> Thyroid medication
<input type="checkbox"/> Cortisone	<input type="checkbox"/> Birth control pills
<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Antacids
<input type="checkbox"/> Pain relievers	<input type="checkbox"/> Sleeping Pills
<input type="checkbox"/> Appetite suppressants	<input type="checkbox"/> 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	Enjoy your work?	Y - N
Have a history of abuse?	Y - P - N	Take vacations?	Y - N
Use recreational drugs?	Y - P - N	Spend time outside?	Y - N
Do you eat three meals a day?	Y - N	Watch television?	Y - N
Do you eat out often?	Y - N	How many hours? _____	
Do you drink coffee?	Y - N	Drink alcoholic beverages?	Y - P - N
Do you drink black/green/herbal teas?	Y - 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:**

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**

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**

Treated for Emotional Problems	Y - P - N	Depression	Y - P - N
Mood Swings	Y - P - N	Anxiety or	Y - P - N
Considered/Attempted suicide	Y - P - N	Nervousness	Y - P - N
Poor Concentration	Y - P - N	Tension	Y - P - N
		Memory Problems	Y - P - N

**Endocrine**

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**

Chronic Fatigue Syndrome	Y - P - N	Chronic Infections	Y - P - N
Chronic Swollen Glands	Y - P - N	Slow Wound Healing	Y - P - N
Reactions to Vaccinations	Y - P - N		

**Neurologic**

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 lips	Y - P - N
Tearing or dryness	Y - P - N	Hoarseness	Y - P - N
Glaucoma	Y - P - N	Difficulty Swallowing	Y - P - N
Impaired hearing	Y - P - N	Goiter	Y - P - N
Earaches	Y - P - N	Swollen glands	Y - P - N
Ringing	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		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/	Y - P - N	Ulcer	Y - P - N
Cramps	Y - P - N	Hemorrhoids	Y - P - N
Belching or Passing	Y - P - N	Poor Appetite	Y - P - N
Gas	Y - P - N	Poor Digestion	Y - P - N
Black Stools	Y - P - N		
Liver Trouble			

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 Reproductive**

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 Reproductive/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 pregnancies____	
PMS Symptoms?_____		Number live births____	
Endometriosis	Y - P - N	Number 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	Had a mammogram ever?	Y - N
Pain During Intercourse	Y - P - N	Last Pap smear date?_____	
Clotting	Y - P - N	Was PAP 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 Shoulders	Y - P - N	Tremors/Twitching	Y - P - N
Painful tail bone	Y - P - N	Arm Trouble	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) \_\_\_Goes 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: \_\_\_\_\_

**Call Now To Schedule Your Appointment: (425) 516-5500**

Please bring these forms filled out to your first appointment or arrive 30-40 minutes early and my receptionist will give you these forms. If you have any questions please give us a call.