JIFUNZA C. WRIGHT, M.D., Sc.D.
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Dear Patient,

Thank you for your courage and commitment to your health and well being. We deliver patient-centered wellness care, which means that you are an active decision-maker in your healthcare management.

I, Dr. Jifunza Wright, and our staff, feel honored to partner in your health and well being. We thank you, and know that your courage and commitment has prompted you to contact us so that you may begin on the road to better health. You will be supported in learning new information and hands on strategies for regaining and maintaining optimal health.

Please create the time to focus on your health and complete the following New Patient Packet. The packet must be completed prior to your appointment

The New Patient Packet contains:

1. **Health Goals and Health Challenge Form -** This information is important so that we may be aware of your health goals and understand the health challenges that have stood in the way of you achieving those health goals.

2. **Past Medical History Form -** This information is important so that we may know your past health history.

3. **Medicines, Vitamins, and Supplements Form -** This information is important so that we may look for possible drug interactions, excessive use, adverse reactions, etc. to insure an optimal therapeutic regimen is reached.

4. **Symptom Survey Form -** This information is important so that we may be aware of any symptoms that you may be experiencing and know how often they are occurring so that we may address the symptoms and use them as a means to monitor your progress.

Please promptly return the packet by email. If the packet is not completed prior to your appointment, we will not be able to optimize our time together and adequately prepare for your session. Consequently, we may be forced to reschedule your appointment. We look forward to partnering with you!

To Your Health,
Jifunza Wright, M.D., Sc.D.

JIFUNZA C. WRIGHT, M.D., Sc.D.

Patient Name:_____ Date:_____

Health Goals

What specific goals do you have to obtain your optimal state of health?

Health Challenges

What specific medical problems have you had that have hindered you from achieving your health goals?

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Past Medical History

ANY HOSPITALIZATION

Reason: Date

ANY SURGERIES

Reason: Date

Chronic Illness:

Other:

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Medicines / Vitamins / Supplements

MEDICATIONS

Name of Medication	Dose / Amount	Frequency	Duration

VITAMINS

Name of Vitamin	Dose / Amount	Frequency	Duration

SUPPLEMENTS

Name of Supplement	Dose / Amount	Frequency	Duration

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Symptom Survey

Please take the time to focus your attention on the following questions. Answer as honestly as possible. This information is key to determining how we can best support you in achieving optimal health. These focal areas are the parameters that we will use to measure your progress. Please use the numbers listed below to rank your answers.

0 - Never 1 - Rarely 2 - Sometimes 3 - Frequently 4 - Always

HAIR

Balding	Breaking	Thinning	Gray	Dandruff	Sores

EYES

Can't see near	Can't see far	Cataracts	Discharge	Itching

NOSE AND SINUSES

Runny Nose	Congestion	Bloody Nose	Headache	Nasal Drip

Other (please describe): _____

MOUTH

Bleeding Gums	Toothache	Sores	Chapped	Dry	Peeling Lips	Bad Breath

SKIN

Acne	Eczema	Dry	Oily	Itching	Sores	Caking	Wrinkles

Please describe any discoloration:_____

Please describe any other eruptions:_____

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GASTROINTESTINAL

Difficulty Swallowing	Indigestion	Stomach Pain

VOMITING

Spontaneous	Induced	Blood in Vomit

GAS

Belching/Burping	Rectal Gas	Bloating	Overeating	Liver Issues	Gallbladder Issues

STOOL

Passing Difficulty	Blood in Stool	Hemorrhoids	Ulcer Polyps	Diarrhea

Please describe frequency, size, shape, and consistency of stool: _____

_____

HEMATOPOIETIC SYSTEM

Low Blood Count	Anemia	Hereditary Blood Disease	Pale	Eat Starch	Eat Ice

URINARY SYSTEM

Burning Sensation	Blood in Urine	Decreased Stream	Unpleasant Smell	Kidney Pain

Feel as if you need to urinate but are unable	Can't get to the bathroom in time

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Women's Health

MENSTRUAL CYCLE

Date of last menstrual cycle:_____ Length of flow (days):_____

Please check one: ▢ Light ▢ Moderate ▢ Heavy

PREMENSTRUAL SYMPTOMS

Cramping	Irritability	Craving	Crankiness	Water Retention	Headaches	Depressed

INTERCOURSE

Pain	Decreased Sexual Desire	Perimenopausal / Menopausal Symptoms

Discharge (please describe):_____

History of Infections:_____

Birth Control: ▢ Yes ▢ No If yes, method _____

Men's Health

OVERALL / SEXUAL

Low energy level / Fatigue	Feeling weak, not as strong	Difficulty with ejaculations	Difficulty with erections

For how long?_____

_____

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NERVOUS SYSTEM

Shaking	Dizziness	Fainting	Shooting Pain	Tingling

SLEEP

Difficulty Getting to Sleep	Difficulty Staying Asleep	Sleeping Less Than 8 Hours

MOOD

Nervousness	Anxiety	Sadness	Anger	Worry

IMMUNE SYSTEM

Frequent Colds / Flu	Fevers	Night Sweats	Chronic Fatigue

LYMPH GLANDS

Enlarged	Painful

HISTORY OF VIRAL INFECTION

Herpes	Mono	CMV	Shingles	HIV

ENDOCRINE SYSTEM - Please describe any problem in the box below each section.

Thyroid	Pituitary	Pancreas	Sex Gland

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MUSCULOSKELETAL PAIN - Please describe any problem in the box below each section.

Muscle	Bone	Joint	Back

Joints - Please describe any problem in the box below each section.

Swollen	Stiff	Arthritis	Range of Motion

RESPIRATORY

Sore Throat	Congestion	Hoarseness	Asthma	Pneumonia	Breathing Difficulty

COUGH

With Phlegm	Without Phlegm	With Blood	With Wheezing	AM Only

CARDIOVASCULAR

Chest Pain	Abnormal Heart Rhythm	Hypertension

SHORTNESS OF BREATH AND INDICES

Walking with shortness of breath	Shortness of breath during exterior	Pain in arm(s): Right/Left	Pain in leg(s) when walking

Please describe your cardiovascular history: _____

_____

_____

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Nutritional Information

Please indicate how frequently you consume the following using the scale below.

0 - Never 1 - Rarely 2 - Sometimes 3 - Frequently 4 - Always 5 - Obsessive Consumption

FLESH

Red Meat	Poultry	Fish	Other

DAIRY

Cheese	Milk	Butter	Eggs	Yogurt	Other

VEGETABLES

Canned	Fresh	Frozen	Cooked >10 Min.	Steamed	Stir Fry

FRUITS

Canned	Fresh	Frozen	Juice

GRAINS

Enriched Grains	Whole Grains	Other

SWEETS

Candy	Cookies	Cakes	Pies	Donuts

BEVERAGES

Regular Tea	Herbal Tea	Fruit Juice	Coffee: Caffeine/Decaf	Water	Soda Pop	Other

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OTHER

Tobacco	Alcohol	Drugs	Other

Are there any other concerns you would like to have addressed that have not been covered in this questionnaire?

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TELEMEDICINE INSTRUCTIONS

Currently, visits will only be conducted via telemedicine. Dr. J utilizes Zoom for appointments, which is fully private, secure, and HIIPA compliant.

After booking your appointment at: https://calendly.com/drjspatients, you will automatically be sent an email including a Zoom link to join your secure appointment. 5 minutes before your appointment begins, please click the Zoom link, enter the password found in the email (when applicable), and you will enter the virtual waiting room. Dr. J will let you in at the start of your appointment time.

While it is up to you whether you want to enable video for the consultation, we highly recommend turning your camera on. With a video connection body language is perceptible, trust is fostered, and communication is clearer.

You do not need to download Zoom software to be able to access your consultation, though it is suggested for a more stable connection and streamlined experience. Please do not begin the installation of Zoom software at the time of your appointment- if you choose to install the software it should be done at least 15 minutes prior to ensure you are ready to go and do not lose any consultation time. To download Zoom software: https://zoom.us/client/latest/Zoom.pkg

If you have any questions about Zoom, please explore: https://explore.zoom.us/resources