PATIENT QUESTIONNAIRE

Name_____ Today's date _____

Height_____ Weight _____ Target weight_____ Occupation _____

MEDICAL HISTORY
(Check if Positive Family History?) [√]

			FH				FH
Diabetes	Yes	No	☐	Organ Recipient	Yes	No	☐
Hypertension	Yes	No	☐	Pacemaker	Yes	No	☐
Thyroid Ds.	Yes	No	☐	Arthritis	Yes	No	☐
Headaches	Yes	No	☐	Cancer	Yes	No	☐
Depression	Yes	No	☐	Eye Disease	Yes	No	☐

SOCIAL HISTORY

Smoke	Yes	No	If yes, how long, how much?
Drink Alcoholic Beverages?	Yes	No	If yes, how long, how much?
Illicit Drugs (MJ, Cocaine, Heroin)	Yes	No	If yes, how long, how much?
Pregnancy	Yes	**(N/A-male)**	List number: No. Delivered CS?
Complications?	Yes	No (N/A-male)	Describe:
Last Menstrual Period?		**(N/A-male)**	Date:
Previous Cleansing/Detoxification	Yes	No	Dates/Types:
Amalgams (metal fillings)?	Yes	No	How many left?
Computer Use	Yes	No	How many hours a day?
Hours spent standing on feet daily?	N/A (sitting)		How many hours a day?
Do you carry backpack/purse?	Yes	No	How many pounds? Over which shoulder?
Repetitive Use (Phone, job, etc,)	Yes	No	How many hours a day?
Do you use a hands-free cell phone?	Yes	No	N/A
How many hours a week do you work?	<20	40	40-60 >60
Do you consider your work stressful?	Yes	No	
Do you drive to work?	Yes	No	If yes, how long is your commute?
How many pillows do you sleep with?	1	2	>2
Which side do you sleep on?	Left	Right	On back On chest
Do you get up at night?	Yes	No	Describe what wakes you up:
Do you have trouble getting to sleep	Yes	No	Describe:
How many hours do you sleep at night?	3-4	4-6	6-8 >8 hours
Do you have a restful sleep?	Yes	No	
Does pain wake you up?	Yes	No	
Are you in chronic pain?	Yes	No	If yes, how long? Describe pain:
Do you exercise?	Yes	No	How many hours? List type?

PREVIOUS ACCIDENT HISTORY

Type (on the job, at home, falling down stairs, ladder, and mis-step) **List Dates, Injury to body**:

_____

_____

Previous Motor Vehicle Accident Yes No **List Dates, Type of collision** –Head on, T-bone, Broadside, Rear-ended, Pedestrian, Motorcycle, Bicycle: (List accident #1, 2, etc. (YEAR it happened) ; Body area affected, including fractures, concussion, ligament tears:

_____

_____

_____

Were you belted? Yes No Driver or passenger?
Did you lose consciousness? Yes No
Did you do physical therapy afterwards? Yes No (How many times a week? How long?)
Did you have any chronic pain resulting from the accident? Yes No

PREVIOUS SURGICAL HISTORY (List date and type of surgery) None

_____

_____

Allergies to Drugs/ Pharmaceuticals/ IV Dye/ Foods/ Latex/ Wool? None (List)

_____

CURRENT MEDICATIONS: **None (List)** _____

_____

_____

CURRENT SUPPLEMENTS (Multi vitamins, Fish Oils, Omega 6, 9, Vitamin E, Calcium, Magnesium, Vitamin D, Probiotics, Homeopathic remedies, Herbs, Green drinks, etc. List)

_____

_____

_____

(Circle the supplements you take *daily*)

EXPOSURE:

Petrochemical solvents (house cleaning fluids, gels, glues, etc.)? Yes No
Industrial solvents? (Home or office) Yes No
Petrochemical shampoos, personal care products? Yes No
Do you use a water filter? Yes No Shower filter? Yes No
Do you use an air filter (HEPA, ozone?) Yes No
Toxic black mold/ mildew? Yes No

DIET

Do you eat a balanced diet with fruits and vegetables, and proteins? Yes No
How much water do you drink (in pints?)
How many meals do you eat a day?
Do you eat organic foods? No 25-50% >50% >75%
Do you eat farm raised salmon vs. wild salmon?
How often do you eat 'Junk Food' (transfats)? Never Sometimes All the time
How much sugar do you consume? None Sometimes All the time
Are you allergic to gluten products (wheat)? No Yes Don't know
Are you allergic to milk.soy, shellfish, corn, peanuts, or eggs? (Circle all that apply)
Are you allergic to nightshade vegetables? No Yes
(eggplant, tomatoes, peppers sensitivity)
Do you have trouble eating meat, or get indigestion after eating meat? Yes No

ENERGY LEVEL? Low Medium High
BOWEL ACTIVITY PER DAY? None 1-2 2-3 > 3
Are you ever constipated? No Daily Sometimes
Do you have loose stools? No Occasionally Always

CONCURRENT TREATMENT PLAN:
Are you also having any of the following treatments?
Acupuncture Massage Physical Therapy Energy Medicine Other

Are you currently restricted from lifting, bending, moving, standing, lying on your back or lying face down for long periods of time? Yes No

Have you ever had problems with the following?

	Yes	No	Comments		Yes	No	Comments
Fever	☐	☐	_____	Weight loss	☐	☐	_____
Hoarseness	☐	☐	_____	Difficulty swallowing	☐	☐	_____
Sinus problems	☐	☐	_____	Vertigo	☐	☐	_____
Chest Pain	☐	☐	_____	Irregular heartbeat	☐	☐	_____
Asthma	☐	☐	_____	High blood pressure	☐	☐	_____
Tuberculosis	☐	☐	_____	Emphysema	☐	☐	_____
Vomiting	☐	☐	_____	Jaundice	☐	☐	_____
Frequent Urination	☐	☐	_____	Loss of appetite	☐	☐	_____
Kidney failure	☐	☐	_____	Kidney stones	☐	☐	_____
Joint swelling	☐	☐	_____	Skin rash	☐	☐	_____
Easy bruising	☐	☐	_____	Seizures	☐	☐	_____
Headaches	☐	☐	_____	Stroke	☐	☐	_____
Mental disorder	☐	☐	_____	Bleeding disorder	☐	☐	_____
Excessive thirst	☐	☐	_____	Migraine	☐	☐	_____
Anemia	☐	☐	_____	High Cholesterol	☐	☐	_____
Seasonal allergies	☐	☐	_____	Sickle cell disease	☐	☐	_____
Other	☐	☐	_____				

Above reviewed and appropriate changes made by _____
Physician Date