Patient Questionnaire

Name: ____ Date:______________________

Describe the condition that you are seeking treatment for: ___________________________________

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How long has the problem existed? ____

Do what extent does this problem interfere with you daily activities? ____________________________

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Have you received a diagnosis for this problem? If so, what? _________________________________

Are you taking any medications for this treatment? If so, what? ______________________________

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What kinds of other treatments have you tried for this condition? ______________________________

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Do you smoke & if so how much? ____

How much alcohol do you consume per week? ____

How much coffee, tea or other caffeinated drinks do you drink per day? _________________________

Do you crave or indulge in any special foods or drinks? If so, what are they? _____________________

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List any surgeries and their dates. ____

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List any major accidents or trauma (include dates). ____

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List medications or vitamins you use. ____

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Are you pregnant? ____

Do you have a regular exercise program? ____

What do you do for relaxation? ____

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Personal and Family Medical History

(Check if you have had any of the following or write in family member that has had one of the following)
(Use abbreviations for family members:F-father, M-mother, B-brother, S-sister, GF-grandfather, GM-grandmother)

______Cancer	_____Diabetes	_____Hepatitis	________Alcoholism
______Seizures	_____Thyroid Disease	_____Veneral Disease	________Drug Addiction
______Stroke	_____High Blood Pressure	______HIV/AIDS	_______Other:___________
______Heart Disease	_____Weight Problem	_____Allergies	_______Other:___________

Please Check if You have experienced any of the following in the last 3 months:

General

Poor Appetite	Localized Weakness	Sudden energy drop	Change in appetite
Fevers	Poor sleeping	Peculiar tastes/smells	Hearing Loss
Fatigue	Excess Thirst	Bleeding/Bruising Easily	Sweat Easily
Tremors	Poor Balance	Weight Loss	Night Sweats
Cravings	Chills	Weight Gain	

Skin & Hair

Rashes	Itching	Dandruff	Ulceration
Eczema	Loss of Hair	Hives	Pimples
Recent Moles			

Head, Eyes, Nose, Throat

Dizziness	Glasses	Poor Vision	Grinding of Teeth
Ringing in Ears	Sinus Problems	Cataracts	Teeth Problems
Gum Problems	Headaches	Concussions	Spots in Front of Eyes
Night Blindness	Blurring Vision	Poor Hearing	Nose Bleeds
Facial Pain	Jaw Click	Migraines	Lip/Tongue Sores
Color Blindness	Earaches	Eye Strain	Recurrent Sore Throats
Eye Pain	Difficulty swallowing		

Cardiovascular

Blood Clots	Fainting	Cold Hands or Feet	High Blood Pressure
Phlebitis	Dizziness	Swelling of Hands	Low Blood Pressure
Chest Pain	Swelling of Feet	Irregular Heartbeat	Difficulty Breathing

Respiratory

Cough	Bronchitis	Asthma	Labored Respiration
Wheezing	Pneumonia	Shortness of Breath	Painful Breathing

Gastrointestinal

Nausea	Constipation	Coughing up Blood	Bad Breath
Belching	Phlegm	Difficulty breathing	Intestinal Gas
Diarrhea	Rectal Pain	Blood in Stools	Abdominal Pain
Indigestion	Hemorrhoids	Black Stools	Vomiting

Genito-Urinary

Pain on urination	Urgency to urinate	Decrease in Urine Flow	Frequent Urination
Blood in urine	Impotency	Unable to Hold Urine	Frequent Night Urination
Genital sores	Kidney Stones	Discolored Urine	

Musculo-Skeletal

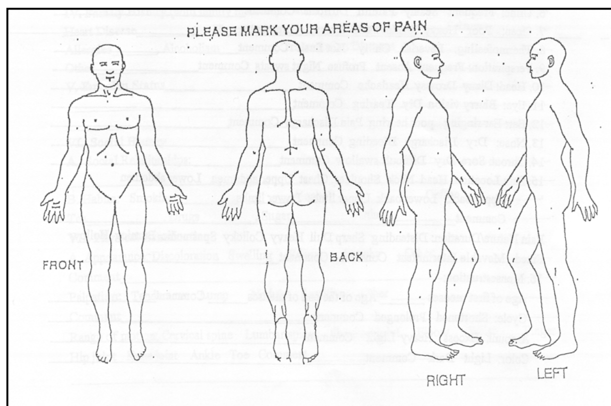
Neck Pain	Back Pain	Hand/Wrist Pain	Muscle Pains
Scoliosis	Shoulder Pain	Knee Pain	Foot/Ankle Pain
Hip Pain	Arthritis	Muscle Weakness	

Gynecology-Pregnancy

Irregular Period	Painful Periods	Vaginal Discharge	# of Pregnancies_______
Clots	Last PAP ____________	Vaginal Sores	# of Births_____________
Premature Birth	Abortions ___________	Miscarriages	Age of 1st Menses___________
Light Flow	Duration of Flow _______	Heavy Flow	Date of Last Menses________

Neuro-Psychological

Seizures	Numb Body Areas	Concussion	Bad Temper
Dizziness	Lack of Concentration	Depression	Loss of Balance
Stress	Poor Memory	Anxiety	Mood Swings



Any Other Comments

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