

NEW PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: _____ Sex: _____ Date: _____

Address: _____ City, State, Zip: _____

Tel Home: _____ Work: _____ Cell: _____

Fax: _____ Email: _____

REFERRED BY: _____

Emergency Contact name _____ Phone _____

Part 1

Please list the 5 major health concerns in your order of importance

1. _____
2. _____
3. _____
4. _____
5. _____

Marital Status S M D W _____ Name of spouse _____

Name of Child	Age	Sex	Any Physical Conditions or concerns
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Part II Please circle the appropriate number 0 – 3 on all questions below

0 (least or never) to 3 (often/always)

Category I

- 0 1 2 3 Feeling that bowels do not empty completely
- 0 1 2 3 Lower abdominal pain relief by passing stool or gas
- 0 1 2 3 Alternating constipation and diarrhea
- 0 1 2 3 Diarrhea
- 0 1 2 3 Constipation
- 0 1 2 3 Hard dry or small stool
- 0 1 2 3 Coated tongue of “fuzzy” debris on tongue
- 0 1 2 3 Pass large amount of foul smelling gas
- 0 1 2 3 More than 3 bowel movements daily
- 0 1 2 3 Use laxatives frequently

Category II

- 0 1 2 3 Excessive belching burping or bloating
- 0 1 2 3 Gas immediately following a meal
- 0 1 2 3 Offensive breath
- 0 1 2 3 Difficult bowel movements
- 0 1 2 3 Sense of fullness during and after meals
- 0 1 2 3 Difficulty digesting fruits and vegetables;
undigested foods found in stools

Category III

- 0 1 2 3 Stomach pain, burning or aching 1- 4 hours after eating
- 0 1 2 3 Frequently use antacids
- 0 1 2 3 Feeling hungry an hour or two after eating
- 0 1 2 3 Heartburn when lying down or bending forward
- 0 1 2 3 Temporary relief from antacids, food, milk, carbonated beverages
- 0 1 2 3 Digestive problems subside with rest and relaxation
- 0 1 2 3 Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol

Category IV

- 0 1 2 3 Roughage and fiber cause constipation
- 0 1 2 3 Indigestion and fullness lasts 2-4 hours after eating
- 0 1 2 3 Pain, tenderness, soreness on left side under rib cage bloated
- 0 1 2 3 Excessive passage of gas
- 0 1 2 3 Nausea and/or vomiting
- 0 1 2 3 Stool is undigested, foul smelling, mucous-like or poorly formed
- 0 1 2 3 Frequent urination
- 0 1 2 3 Increased thirst and appetite
- 0 1 2 3 Difficulty losing weight

Category V

- 0 1 2 3 Greasy or high fat foods cause distress
- 0 1 2 3 Lower bowel gas and or bloating several hours after eating
- 0 1 2 3 Bitter metallic taste in mouth, especially in the morning
- 0 1 2 3 Unexplained itchy skin
- 0 1 2 3 Yellowish cast to eyes
- 0 1 2 3 Stool color alternates from clay colored to normal brown
- 0 1 2 3 Reddened skin, especially palms
- 0 1 2 3 Dry or flaky skin and/or hair
- 0 1 2 3 History of gallbladder attacks or stones
- Yes No Have you had your gallbladder removed?

Category VI

- 0 1 2 3 Crave sweets during the day
- 0 1 2 3 Irritable if meals are missed
- 0 1 2 3 Depend on coffee to keep yourself going or started
- 0 1 2 3 Get lightheaded if meals are missed
- 0 1 2 3 Eating relieves fatigue
- 0 1 2 3 Feel shaky, jittery, tremors
- 0 1 2 3 Agitated, easily upset. Nervous
- 0 1 2 3 Poor memory, forgetful
- 0 1 2 3 Blurred vision

Category VII

- 0 1 2 3 Fatigue after meals
- 0 1 2 3 Crave sweets during the day
- 0 1 2 3 Eating sweets does not relieve cravings for sugar
- 0 1 2 3 Must have sweets after meals
- 0 1 2 3 Waist girth is equal or larger than hip girth
- 0 1 2 3 Frequent urination
- 0 1 2 3 Increased thirst & appetite
- 0 1 2 3 Difficulty losing weight

Category VIII

- 0 1 2 3 Cannot stay asleep
- 0 1 2 3 Crave salt
- 0 1 2 3 Slow starter in the morning
- 0 1 2 3 Afternoon fatigue
- 0 1 2 3 Dizziness when standing up quickly
- 0 1 2 3 Afternoon headaches
- 0 1 2 3 Headaches with exertion or stress
- 0 1 2 3 Weak nails

Category IX

- 0 1 2 3 Cannot fall asleep
- 0 1 2 3 Perspire easily
- 0 1 2 3 Under high amounts of stress
- 0 1 2 3 Weight gain when under stress
- 0 1 2 3 Wake up tired even after 6 or more hours of sleep
- 0 1 2 3 Excessive perspiration or perspiration with little or no activity

Category X

- 0 1 2 3 Tired, sluggish
- 0 1 2 3 Feel cold - hands, feet or all over
- 0 1 2 3 Require excessive amounts of sleep to function properly
- 0 1 2 3 Increase in weight gain even with low-calorie diet
- 0 1 2 3 Difficult, infrequent bowel movements
- 0 1 2 3 Depression, lack of motivation
- 0 1 2 3 Morning headaches that wear off as the day progresses
- 0 1 2 3 Outer third of eyebrow thins
- 0 1 2 3 Thinning of hair on scalp, face or genitals or excessive hair loss
- 0 1 2 3 Dryness of skin and/or scalp
- 0 1 2 3 Mental sluggishness

Category XI

- 0 1 2 3 Heart palpitations
- 0 1 2 3 Inward trembling
- 0 1 2 3 Increased pulse even at rest
- 0 1 2 3 Nervous and emotional
- 0 1 2 3 Insomnia
- 0 1 2 3 Night sweats
- 0 1 2 3 Difficulty gaining weight

Category XII

- 0 1 2 3 Diminished sex drive
- 0 1 2 3 Menstrual disorders or lack of menstruation
- 0 1 2 3 Increased ability to eat sugars without symptoms

Category XIII

- 0 1 2 3 Increased sex drive
- 0 1 2 3 Tolerance to sugars reduced
- 0 1 2 3 Splitting type headaches

Category XIV (Male Only)

- 0 1 2 3 Urination difficulty or dribbling
- 0 1 2 3 Urination frequent
- 0 1 2 3 Pain inside of legs or heels
- 0 1 2 3 Feeling of incomplete bowel evacuation
- 0 1 2 3 Leg nervousness at night

Category XV (Males Only)

- 0 1 2 3 Decrease in libido
- 0 1 2 3 Decrease in spontaneous morning erections
- 0 1 2 3 Decrease in fullness of erections
- 0 1 2 3 Difficulty in maintaining morning erections
- 0 1 2 3 Spells of mental fatigue
- 0 1 2 3 Inability to concentrate
- 0 1 2 3 Episodes of depression
- 0 1 2 3 Muscle soreness
- 0 1 2 3 Decrease in physical stamina
- 0 1 2 3 Unexplained weight gain
- 0 1 2 3 Increase in fat distribution around chest and hips
- 0 1 2 3 Sweating attacks
- 0 1 2 3 More emotional now than in the past

Category XVI (Menstruating Females Only)

- Yes No Are you a menopausal?
- Yes No Alternating menstrual cycle lengths?
- Yes No Extended menstrual cycle, greater than 32 days?
- Yes No Shortened menses, less than every 24 days?
- 0 1 2 3 Pain and cramping during periods
- 0 1 2 3 Scanty blood flow
- 0 1 2 3 Heavy blood flow
- 0 1 2 3 Breast pain and swelling during menses
- 0 1 2 3 Pelvic pain during menses
- 0 1 2 3 Irritable and depressed during menses
- 0 1 2 3 Acne break outs
- 0 1 2 3 Facial hair growth
- 0 1 2 3 Hair loss/thinning

Category XVII (Menopausal Females only)

- 0 1 2 3 How many years have you been menopausal?
- Yes No Do you ever have uterine bleeding since menopause?
- 0 1 2 3 Hot flashes
- 0 1 2 3 Mental fogginess
- 0 1 2 3 Disinterest in sex
- 0 1 2 3 Mood swings
- 0 1 2 3 Depression
- 0 1 2 3 Painful intercourse
- 0 1 2 3 Shrinking breast
- 0 1 2 3 Facial hair growth
- 0 1 2 3 Acne
- 0 1 2 3 Increased vaginal, pain, dryness or itching

Part III

How many caffeinated beverages do you consume per day? \neq _____

How many alcoholic beverages they consume per week? _____

How many times do you eat out per week? _____

How many times per week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____

How many times a week do you workout? _____ Describe? _____

List the three worst foods you eat during the average week: _____

List the three healthiest foods you eat during the average week: _____

Do you smoke? ____ If yes, how many times a day ____ a week? _____

Rate your stress levels on a scale of 1-10 during the average week. _____

Have you had any surgeries (including cosmetic)? _____ If so, what kind? _____

Are you on or have you ever taken birth control pills? ____ How long? _____

Are you now or have you ever been on estrogen/progesterone replacement therapy? _____

Do you have silver amalgam fillings? ____ How many at present? _____

How many removed? _____ Were dental precautions utilized? _____

Root canals? ____ How many? _____ Crowns? ____ How many? _____

Is there pain in any of your teeth? ____ Which ones? _____

Do you still use aluminum cookware or commercial deodorants? _____

Describe what diseases are predominant in you family? _____

Please list any medications you currently take and for what conditions: _____

Please list any natural supplements or herbs you currently take and for what conditions: _____

Please give a diet summary for a typical 3 day period (use a separate page if necessary)

What can we do to make you happier? _____