New Patient Questionnaire

Name:________________________ Date of Birth:_________ Sex:____ Date:_______
Address:___________________ City, State, Zip:________________________________
Tel Home:_________________ Work:________________ Cell:______________________
E-mail:__________________________Fax:__________________
Referred by:__________________________Employer________________________
Emergency Contact name___________________________ Phone________________________

Part 1
Please list the 5 major health concerns in your order of importance

1.____
2.____
3.____
4.____
5.____

What are your goals for your health and well being?

____
____
____

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 or 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 light headed 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 palpations
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 XII
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? ##________________________________
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 l-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)
____
____
____
____
____

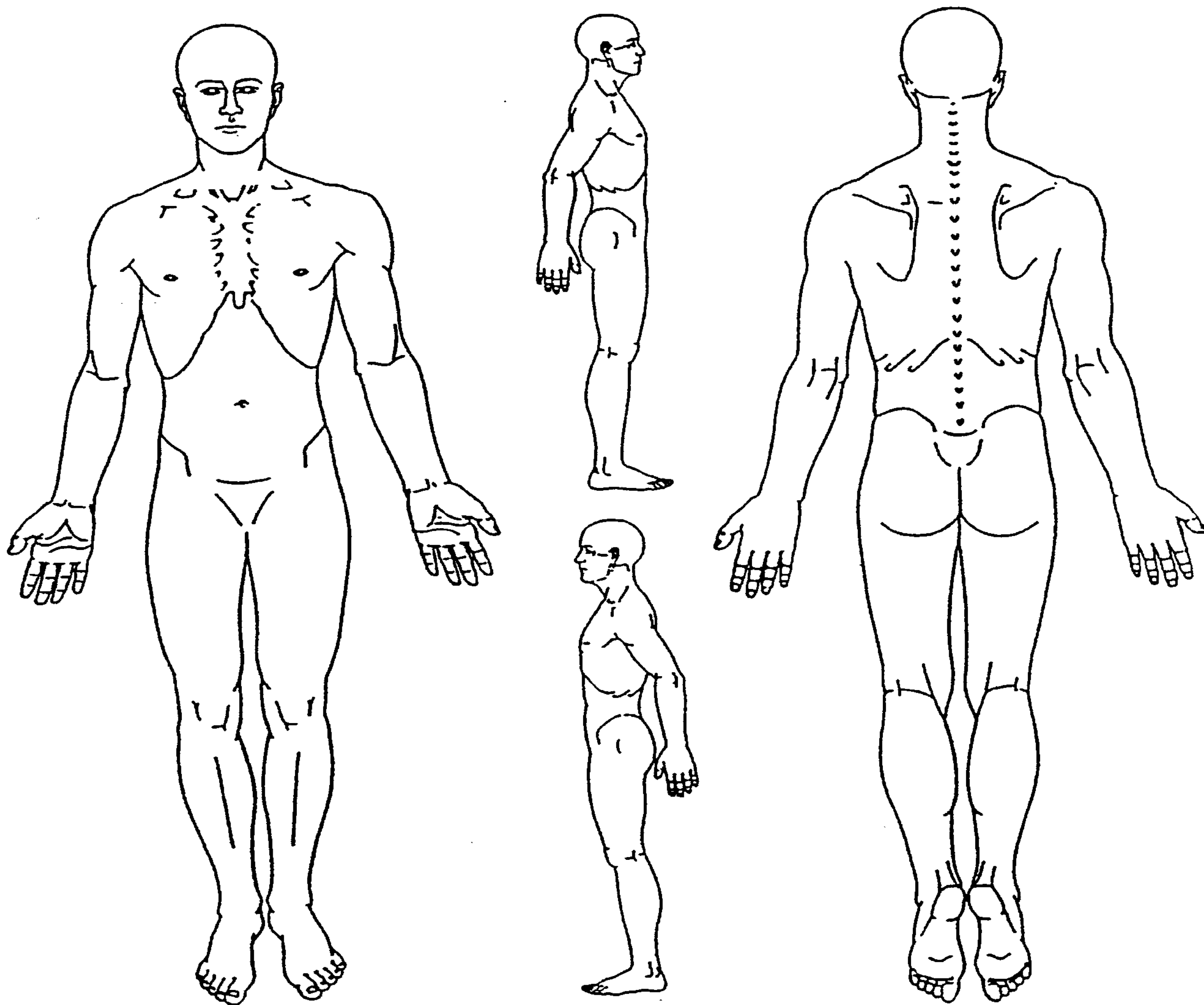
Please bring this filled out form to your first appointment or fax it to: 760-652-1654

Structural Symptoms

Name ______________________ Please indicate if you have any of the following

- ☐ Low Back Pain
- ☐ Muscle Spasms
- ☐ Muscle Fatigue
- ☐ Arthritis
- ☐ Headaches
- ☐ TMJ/Jaw Pain
- ☐ Shoulder Pain
- ☐ Elbow Pain
- ☐ Wrist Pain
- ☐ Hip Pain
- ☐ Sciatic Pain
- ☐ Knee Pain
- ☐ Ankle Pain
- ☐ Foot Pain
- ☐ Unstable/Weak Muscles
- ☐ Unable to Hold Adjustments
- ☐ Other ____________________
- ☐ Other ____________________
- ☐ Other ____________________
- ☐ Other ____________________
- ☐ Other ____________________

Please Mark Your Areas of Pain or Discomfort



Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other

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Healing Partnership

Bryan Stern L.ac 760-943-7848

Check Health Issues	Current	Past	Check Health Issues	Current	Past
Acidity/Acid reflux			Gout		
Addiction			Head		
Anemia			Headaches/Migraines		
Anger, Impatience			Hemorrhoids		
Anorexia			Hernia		
Arteriosclerosis			HIV/AIDS		
Arthritis			Immune system		
Asthma			Jaundice		
Blood			Lethargy		
Blood Pressure			Metabolic/Endocrine		
Bones			Menopause		
Bronchitis			Mouth		
Cancer			Muscles		
Cardiovascular			Nervous System		
Cholesterol			Nose		
Colic/abdominal pain/distention			Rectum		
Colon			Reproductive		
Constipation			Respiratory		
Diarrhea			Overweight		
Diabetes			Parasites		
Ears			PMS		
Edema			Rheumatism		
Emotional			Sinus		
Environmental allergies			Skin disorders		
Epilepsy			Small intestine		
Epstein Barr			Throat		
Eyes			Thyroid (hyper/hypo)		
Fever			Tumors		
Food allergies			Ulcer		
Fibromyalgia			Worry, Fear, Anxiety, Nervous		
Gall Bladder			Other		
Gastrointestinal			Other		