

NEW PATIENT QUESTIONNAIRE

Date _____ E-Mail Address _____

First _____ Middle _____ Last _____

Home Address _____

City, State, Zip _____

Home Phone () _____ Cell () _____

Birth Date _____ Current Age _____ S.S.N. _____

Referral Name _____

Marital Status _____ No. of Children _____

Children's Ages _____

Your Occupation _____

Patient's Employer _____

Business Address _____

City, State, Zip _____

Business Phone () _____

Name of Spouse _____ Spouse's S.S.N. _____

Primary Insurance Company _____

Name of Insured _____

Group No. / Policy No. _____

Secondary Insurance Company _____

Group No. / Policy No. _____

I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature _____ Date _____

Background Information:

Primary Physician _____ Phone _____

Date of Last Physical Exam _____

Abnormal Findings _____

Date of Last Blood Test _____

Abnormal Findings in Blood Test _____

Date of Last PAP Smear (Females Only) _____

Abnormal Findings in PAP (Females Only) _____

Date of last Mammogram (Females Only) _____

Abnormal Findings in Mammogram (Females Only) _____

Present complaint(s) or illness(es):

Illness Duration _____

Events preceding onset:

How long since you've been well _____

Personal Health Goals:

List travel immunizations _____

Recent flu shots _____

Do you have mercury amalgam fillings? _____ If yes, how many? _____

Do you have root canals? _____ If yes, how many? _____

List any Accidents you have had with dates:

List any Surgeries you have had with dates:

Medications that you are currently taking (include birth control pills and non-prescription drugs, including vitamins/supplements). Indicate the dosage, length of time taking the medication, and frequency of use.

Have you ever had a frequent or prolonged use of the following drugs, if so, provide your age at the time and for how you took them?

Antibiotics _____

Antihistamines _____

Cortisone _____

Prednisone _____

Steroids _____

Describe how you feel about these issues (**G**=Great / **O**=Okay / **P**=Problem):

Spouse _____

Significant other _____

Children _____

Work _____

Sex Life _____

Finances _____

Describe how you feel about your life in general:

Do you smoke cigarettes now? _____ Have you smoked? _____

How much? _____ How long? _____

Alcohol Usage: Alcohol Type _____

Alcohol Amount _____ Frequency _____

Do you now or have you ever had a problem with drugs? _____

If yes, describe: _____

How often do you exercise? _____

What type of exercise? _____

For how long? _____

Would you describe your stress levels as low, moderate or high? _____

Describe the kind of work you do: _____

How often do you have bowel movements? _____

What kind of water do you drink? _____

Do you have a purifier? _____ What kind? _____

Do you use an electric blanket? _____

List any allergies or sensitivities to drugs, supplements, herbs, foods, pollens, animals, or chemicals:

For the following illnesses, check the box if you have now or have had them, and include description, now vs. prior, treatment/action taken, and dates:

- Cancer _____
- AIDS/ HIV _____
- High Blood Pressure _____
- Elevated cholesterol _____
- Diabetes _____
- Heavy Metal Toxicity _____
- Major Dental Problems _____
- Rheumatoid Arthritis _____
- Lupus/ Auto-Immune illness _____
- Multiple Sclerosis _____
- Hepatitis/ Liver Disease _____
- Gall Stones _____
- Kidney Stones _____
- Low blood Pressure _____
- Hypoglycemia _____
- Candida _____
- Food/ Environmental Allergies _____
- Anemia _____
- Asthma _____
- Breast Cysts _____
- Osteoporosis _____
- Endometriosis _____
- Weight Disorder _____
- PMS _____
- Excessive Fatigue _____
- Miscarriage(s) _____
- Abdominal Pain _____
- Ovarian Cysts _____
- Gonorrhea/ Syphilis/ Chlamydia _____
- Fibroid _____
- Herpes _____
- Shingles _____
- Ulcerative Colitis/ Crohn's Disease _____
- Depression/ Nervous Breakdown _____
- Insomnia _____
- Attempted Suicide _____
- Mono/ EBV/ CMV _____
- Pneumonia _____
- Eczema/ Psoriasis _____
- Thyroid Disease _____

Additional Questions:

1) What % of your body's healing power do you feel you are using now? _____

2) How long do you think it will take for you to regain your health?

3) What lifestyle/dietary changes do you think you need to make to feel better?

4) What emotional or stress-related factors are of concern to you currently?

5) What do you do to reduce stress in your life?

6) How will your life be different when you regain your health?

7) How can I help you reach a state of OPTIMAL HEALTH?

Thank you for taking the time to complete this and for your thorough answers.

Female Hormone Questionnaire

initials _____

Current Age

Approximate date of last menstrual period

Approximate date of last menstrual period at time when your periods were regular

Age of onset of menstruation (Menarche)

How long after Menarche did your periods get regular?

How many days did your menstrual flow last at that time?

What was cycle length when periods got regular at that time?

(number of days from the first day of menstrual flow of one cycle, to the first day of flow of the next)

Prior to the age of 18 or, your first pregnancy:

did you have "PMS" ___yes ___no

did you have difficult periods ___yes ___no

? breast tenderness: ___yes ___no ? headaches: ___yes ___no

___irritability? ___uterine cramps? ___heavy flow? ___bloating?

Birth control methods: ___Diaphragm ___Condom ___both ___IUD [___# of years] ___tubal ligation

Were you ever on the Birth Control Pill? ___yes ___no ___# of years or ___# of months

If 'yes', how did you feel on it? ___better ___worse

did you gain weight while on it? ___yes ___no

Number of ... ___miscarriages ___abortions

Have you ever been pregnant & given birth? ___yes ___no if yes, number of births ___

Your age at each pregnancy

Number of months you breast fed this baby _____

After the first 3 months was pregnancy

a very physically pleasant time for you? ___yes ___no

a worse time for you than non-pregnant? ___yes ___no

did you have diabetes during pregnancy? ___yes ___no

did you have nausea of pregnancy? ___yes ___no for how long? ___

Have you had a recurrence or worsening of premenstrual symptoms after the age of 35: ___yes ___no

___PMS ___breast tenderness

After the age of 35, before menopause,

Is there a time of the month that you feel best? week: ___1 ___2: ___3: ___4

Is this the only time of the month you feel good? ___yes ___no

Breast size when younger or, prior to first pregnancy: ___small ___medium ___large

Current breast size: ___smaller than above ___larger than above

have you had any of the following:

___breast cysts ___breast biopsy ___breast cancer

have you had breast mammograms? if so, how many _____? any abnormal _____?

have you had breast ultrasounds? if so, how many _____? any abnormal _____?

have you had breast thermograms? if so, how many _____? any abnormal _____?

do you have breast implants (if so, when implanted _____?)

what percentage of time in a 24 hour day do you wear a bra? _____%

Have you had any of the following:

uterine fibroids D & C [# of] ovarian cysts endometriosis
 laparoscopic surgeries cesarian sections tubal ligation endometrial biopsy
 hysterectomy: at what age ? oophorectomy [removal of ovary(s)] ? _1 ? _2
 age of last pap smear ? abnormal pap smear [at what age ?]
 bone density tests _____ date of last one normal osteopenia osteoporosis

Hormonal use: Premarin Provera patch
 other hormones [list] _____

has any woman in your family had female cancer? no yes
if yes, who and what type? breast uterine ovarian
who? _____

Current Height _____ feet _____ inches
tallest height you ever were _____ feet _____ inches
Weight age 25 _____ lbs Weight now _____ lbs
In your life have you had more muscle and hair than others? _____
more muscle than others with little body hair? _____?

Symptoms of estrogen deficiency:

hot flashes warm rushes temperature swings night sweat
 kicking covers off at night vaginal dryness racing mind @ night
 trouble falling asleep mental fogginess depression
 headaches & migraines intestinal bloating diminished sexuality & sensuality
 weight gain back & joint pain heart palpitations

Symptoms of estrogen excess:

breast tenderness [especially central] breast swelling or enlarging
 water retention & swelling impatient & snappy though with clear mind
 pelvic cramps nausea

Symptoms of progesterone deficiency:

difficulty sleeping anxiety & nervousness water retention
 no period infrequent period shorter cycle
 frequent & heavy periods spotting before period PMS
 cystic breasts painful breasts endometriosis fibroids

Symptoms of testosterone deficiency:

diminished sex drive flabbiness
 diminished energy & stamina diminished sense of security
 diminished coordination & balance indecisiveness
 diminished armpit, pubic & body hair hair loss
 diminished love of your body image muscle weakness

QUESTIONS FOR PATIENTS

- 1) What is your main complaint, and why, and how does it trouble you?
- 2) Do you have pain, and rate it on a scale of 1-10.
- 3) What do you expect this type of medicine, and particularly the diet changes, to do for you?
- 4) Were you breast fed, and for how long?
- 5) As a child, were you susceptible to infections
- 6) Have your tonsils or adenoids been removed? Or have you had an appendectomy?
- 7) As a child, did you have eczema, any other skin problems, or allergies?
- 8) Do you have mercury fillings or root canals?
- 9) Have you had alot of antibiotics?
- 10) What vaccinations have you received?
- 11) Are you following any particular diet?
- 12) Do you often feel very tired after a meal?
- 13) Do you often get attacks of intense hunger, so that you simply have to eat something?
- 14) Do you have regular bowel movements?
- 15) Are there any foods that you do not tolerate, or are especially fond of?
- 16) How much, and what, do you drink every day?
- 17) Do you sleep well? Do you snore?
- 18) What are you most afraid of?
- 19) What do you consider to be the cause of your problem?
- 20) Imagine that a wizard came along and could grant you one wish, but you can't request a wish for healing or to receive magical powers to change everything. What would you wish for?