

ADULT QUESTIONNAIRE

PERSONAL INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

Home Address: _____ Phones: (Home) _____

_____ (Cell) _____

Email: _____ (Work) _____

Birth Date: ____/____/____ ___ Female, ___ Male SSN (optional): _____

Height: _____ Weight: _____ lbs

Occupation: _____

Referred by: _____

Current Diagnosis (list all) _____

HEALTH INSURANCE INFORMATION:

* Please note: I do not accept any health insurance. You are responsible for submitting your own claims. *

Primary Health Insurance: _____ ID/Group #: _____

Secondary Health Insurance: _____

OTHER:

Primary Care Physician: _____ Phone: _____

Fax #: _____ City, State: _____

GENERAL: Referred by: _____

Primary Complaint: _____

Goals for the visit: _____

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SPECIALISTS Include MDs. Naturopaths, Homeopaths, other therapists

NAME	SPECIALTY	PHONE NUMBERS	CITY, STATE	LAST VISIT

PAST MEDICAL HISTORY:

CONDITION	PAST TREATMENTS	CURRENT TREATMENTS	APPROXIMATE DATE (S) of TREATMENT

CURRENTMEDICATIONS, VITAMINS, MINERALS, and OTHER NUTRITIONAL SUPPLEMENTS:

EARLY HEALTH HISTORY:

Did your mother have any known problems during her pregnancy with you (illness, stress, medications, smoking, vaccines, alcohol)? _____

Were you breastfed or bottlefed? If breastfed, please indicate duration _____

Did you have any significant stresses in childhood or adolescence? If yes, please explain _____

Please check if you had any of the following childhood illnesses?

Frequent Ear, Throat or other Infections Colic Reflux Meningitis Thrush

Asthma Chicken Pox Eczema Frequent Colds Other _____

Did you take _____ antibiotics or _____ steroid medications frequently?

Did you receive standard childhood immunizations? _____

Did you ever have adverse reactions to vaccines? If yes, please explain _____

FEMALE SPECIFIC INFORMATION

Age at first period _____ Date of last period _____ Length of cycles _____

History of irregular/abnormal periods? Yes, No If yes, please describe: _____

Please check if you have a history of Endometriosis Fibroids Polycystic Ovarian Syndrome?

Describe any premenstrual symptoms _____

Are you taking birth control pills? _____ If yes, for how long? _____ If no, have you ever taken them? _____

Any known history of Infertility problems? _____ If yes, please explain _____

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Pregnancies: None _____ Term Births _____ Miscarriages _____ Abortions _____

Are you currently pregnant? _____ If so, what is your due date? _____

Illnesses or complications during pregnancy or labor and delivery

Medications taken during pregnancy or labor and delivery _____

If you have ever had a C-Section, please explain _____

Any complications for you after delivery _____

Any history of breast problems (tenderness, cysts, etc)? _____

Any history of yeast infections? If yes, please explain _____

FAMILY HISTORY:

List any allergies, major illnesses, genetic diseases or problems (such as digestive issues or mental health problems) for each family member.

Mother _____

Father _____

Maternal Grandparents _____

Paternal Grandparents _____

Other _____

SOCIAL and LIFESTYLE HISTORY:

With whom do you live? Include children, parents, relatives, friends, etc and their ages.

Recent changes, major losses, births, deaths, divorce, remarriage, moves, etc. _____

How many hours of SLEEP per night do you average? _____ Any difficulty falling asleep or waking up? _____

Quality of sleep? _____

EXERCISE: ___None Type _____ Frequency _____

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Recent TRAVEL (location, duration, vaccines prior to travel or illnesses during/after that you think relate to the travel):

ALCOHOL: ___Never If yes, frequency_____ Any alcoholics in your family?_____

TOBACCO: ___Never ___Smoked or ___Smoking ___ packs/day from age ___ to ___.

If still smoking, have you ever tried to quit? ___ What methods?_____

What are your general EATING HABITS (overeate, undereat, picky, etc)?_____

Have you been on any diets? Please explain (including results and patterns of loss and gain)_____

Have you ever had an eating disorder? If yes, which one(s)?_____

DIETARY/NUTRITIONAL/DIGESTIVE HISTORY:

Are you currently following a special diet? Please explain_____

Known food allergies_____

Suspected food SENSITIVITIES_____

Food CRAVINGS (e.g. bread, pasta, cheese, salty foods, sodas/coffee/tea with or without caffeine, alcohol, milk, etc):

STOOL pattern (frequency, color, odor, consistency)_____

Do you or have you ever had gastrointestinal problems? Please Describe_____

Please list the foods and beverages normally consumed by you in a typical three day period.

DAY 1

Breakfast	
Morning Snack (s)	

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Lunch	
Afternoon Snack (s)	
Dinner	
Other	

DAY 2

Breakfast	
Morning Snack (s)	
Lunch	
Afternoon Snack (s)	
Dinner	
Other	

DAY 3

Breakfast	
Morning Snack (s)	
Lunch	
Afternoon Snack (s)	
Dinner	
Other	

ENVIRONMENTAL/ALLERGY HISTORY:

LOCATION: ___City ___Suburban ___Wooded ___Farm ___Other_____

WATER: ___City ___Well If you have a purification system, please describe_____

Type of HEAT: ___Electric ___Gas ___Oil ___Other_____

Do you live near: ___Power lines ___Woods ___Industrial areas ___Water Type (ocean, swamp, etc)_____

Does your home have a lot of: ___Dust ___Mold ___Down/Feather items (pillows, stuffed animals, etc)

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Are there specific areas in your home that you suspect have issues? Please describe _____

Bedding: ___Synthetic ___Down ___Feather ___Mattress cover

Flooring: ___Wall-to-Wall Carpet ___Area rug ___Wood ___Glued down ___Synthetic Pad

Any known exposure to harmful chemicals? _____

Do you have any known ALLERGIES to food and/or medications? If yes, please list names and describe reactions:

CHECK WHERE APPROPRIATE:

- ___ Tick infested area ___ Tick found on household pets
 ___ Frequent outdoor activities ___ Vacation to high risk area ___ Hiking, fishing, camping or hunting
 ___ Other household members with tick exposure and/or Lyme ___ Gardening

Are you sensitive to any of the following? Check where appropriate.

- ___Perfumes/Cosmetics ___Cleaning Products ___Mold ___Paint
 ___Pollens/Grasses ___Soaps ___Animals (dander)
 ___Detergents ___Dust ___Gasoline ___Tobacco Smoke
 ___Other→Please Describe _____

Are there foods that you avoid because of how they make you feel? Explain _____

Please mark which tests have been done and provide date and results.

EVALUATION—TEST	DATE	RESULTS (Normal, Abnormal) * Please send results/reports with this form *
Blood Chemistry (Including Liver Function Tests)		
Blood Count (CBC)		
IgG Food Sensitivity Panel		
IgE Environmental Allergy Panel		
EKG		
EEG		
Hair Elements		
Urine Toxic Metals and Elements		

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Homocysteine		
Folic Acid		
Serum—Methylmalonic Acid		
Immune Profile		
Urine—Organic Acids		
Amino Acids		
Plasma or Serum Zinc		
Plasma or Serum Copper		
RBC Elements		
Iron Studies (Ferritin, % Iron Saturation, TIBC, etc)		
Thyroid Panel (TSH, etc)		
Serum Vitamin Levels (Specify)		
Stool Culture		
Stool Ova and Parasites		
Uric Acid (blood or urine)		
OTHER		

Please list THERAPIES you have used or are using now...and check the appropriate RESPONSE you had.

NOW	PAST	THERAPY	Good	None	Bad	Comments
		Acupuncture				
		Psychiatrist				
		Homeopathy				
		Naturopathy				
		Occupational Therapy				

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		Physical Therapy				
		Psychologist				
		Craniosacral				
		Energy Therapy				
		OTHER				

CURRENT SIGNS + SYMPTOMS: Please check where appropriate. Leave row blank if not applicable.

DESCRIPTION	MILD	MODERATE	SEVERE	DETAILS
Fatigue				
Difficulty falling asleep				
Difficulty staying asleep				
Nighttime waking				
Night walking				
Nightmares				
Fever				
Heat intolerance				
Cold intolerance				
Flushing				
Headache – Specify type				
Distorted senses – Specify if Vision, hearing, taste, smell				
Low self esteem				
Trouble remembering				
Seizures				
Anxiety				
Irritability				
Depression				
Panic Attacks				
Dizziness				
Fainting				
Difficulty with concentration				
Difficulty with balance				
Numbness/Tingling				
Mood swings				
Conjunctivitis				
Ear ringing				
Hearing loss				
Sensitive to lights or loud noises				
Sore throats				
Congestion				
Dark circles/ puffiness under eyes				
Sinus infections				
Post nasal drip				

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Loss of smell				
Loss of taste				
Bad breath				
Nose bleeds				
Hoarseness				
Cough—Dry				
Cough—Productive				
Wheezing				
Seasonal Allergies				
Heart Attack				
Muscle cramps				
TMJ problems				
Chest tightness				
Muscle weakness				
Muscle stiffness				
Joint stiffness				
Joint pain				
Poor appetite				
Bad teeth				
Gum bleeding				
Dry mouth				
Geographic tongue (map-like rash on the tongue)				
Cold sores				
Cracking at corner of lips				
Heartburn				
Nausea				
Vomiting				
Abdominal pain				
Bloating				
Belching				
Diarrhea				
Constipation				
Undigested food in stool				
Mucous in stool				
Blood in stool				
Hemorrhoids				
Difficulty swallowing				
Eczema				
Hives				
Rash				
Athletes foot				
Acne				
Easy bruising				
Ears get red				
Sensitive to bug bites				
Pale skin				
Dry skin				
Itchy skin				
Cracking or peeling of feet				
Cracking or peeling of hands				

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Nail biting				
Soft nails				
White spots on nails				
Thickening of nails				
Fungus on nails				
Ridges on nails				
Pitting of nails				
Urinary urgency				
Urinary leaking				
Urinary pain				
Urinary hesitancy				
Bed-wetting				
Kidney stones				
Blood in urine				
Prostate enlargement				
Jock itch				
Vaginal discharge				
Vaginal itching				
Post-Menopausal bleeding				
Tics				
Night blindness				
Gum disease				
Dry lips				
Teeth grinding				
Tremors				
Psoriasis				
Strong body odor				
OCD behavior				
Reflux				
Thrush				

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B complex
 __ Insomnia
 __ Dermatitis, patchy skin
 __ Fatigue
 __ Sugar craving
 __ Irritability, depression

Thiamin
 __ Anxiety, Fear
 __ Sleep disturbance
 __ Irritability
 __ Poor coordination
 __ Increased Alcohol/sushi
 __ swelling

B2 (riboflavin)
 __ Neuropathy
 __ dermatitis
 __ lack of taste, stomatitis
 __ Cracked lips
 __ watery or bloodshot eyes

B3(Niacin)
 __ abdominal discomfort
 __ Nausea or diarrhea
 __ Depression,
 __ poor memory, confusion
 __ rough skin
 __ canker sores
 __ bad breath

B5 (pantothenic acid)
 __ Fatigue
 __ burning or numb feet
 __ cramps, abdominal distress
 __ acne
 __ poor coordination
 __ hair loss

B6
 __ acne
 __ dermatitis,
 __ muscle weakness
 __ irritability, depression
 __ poor immunity
 __ tooth decay
 __ fatigue
 __ Oxalates

__ Anemia
 Folic Acid
 __ Fatigue
 __ diarrhea
 __ sulfa drugs
 __ anemia

B12
 __ Poor memory
 __ vegetarian diet
 __ Viral infection, shingles
 __ depression
 __ poor balance

Biotin
 __ muscle pain
 __ depression
 __ hair loss
 __ dermatitis

Calcium
 __ brittle nails
 __ cramps
 __ depression
 __ tooth decay
 __ insomnia
 __ high soda intake

Choline/Inositol
 __ Depression
 __ Memory loss
 __ fat intolerance

Chromium
 __ anxiety
 __ fatigue
 __ poor glucose control

Copper
 __ anemia
 __ depression
 __ diarrhea
 __ fatigue
 __ hair loss
 __ bruising

Copper excess
 __ anxiety
 __ ringing in ears
 __ sensitive to metals
 __ poor concentration

Iodine
 __ Fatigue
 __ weight gain
 __ hypothyroidism
 __ dry skin and hair
 __ puffy face
 __ poor memory

Iron
 __ Anemia
 __ Brittle nails
 __ Confusion, poor memory
 __ Headaches
 __ Mouth/tongue sores
 __ Fatigue

Magnesium
 __ constipation
 __ muscle spasms
 __ insomnia
 __ anxiety
 __ hyperactivity
 __ restless leg
 __ teeth grinding
 __ headache/migraine

Manganese
 __ dizziness
 __ ringing in ears
 __ poor glucose control
 __ Seizures
 __ Mottled skin tone

Molybdenum
 __ Acne
 __ PMS
 __ Migraines
 __ Caffeine intolerance
 __ silfite/nitrite intolerance

Potassium
 __ Diarrhea

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edema
 difficulty breathing
 muscle cramps

Selenium
 Fatigue
 pancreatic insufficiency
 immune impairment

Sodium
 Cramps
 constipation
 PMS, morning sickness

Zinc
 Acne
 brittle nails
 depression
 delayed puberty
 poor growth
 hair loss
 impotence/infertility
 poor appetite arms
 low stomach acid
 Poor immunity
 White spots on nails

Vitamin A
 Night blindness
 acne
 CF
 dry skin/hair
 infertility
 URI
 poor growth

Vitamin C
 bleeding gums
 easy bruising
 poor wound healing
 loose teeth
 Wrinkled skin
 joint pain

Vitamin D
 burning mouth
 diarrhea
 insomnia

seasonal depression
 psoriasis
 scalp sweating
 poor coordination

Vitamin E
 altered gait
 poor reflex
 CF, Infertility
 dry, itchy skin
 breast cysts

Vitamin K
 bleeding ulcers
 nose bleeds, bruising
 liver or kidney disease

Essential Fatty Acids
 Dry, flaky skin
 cracking peeling hands/feet
 clear bumps on upper arms
 dandruff/cradle cap
 splitting, dull nails
 ear wax
 acne
 excess thirst
 poor attention

Pyroluria
 Poor dream recall
 white spots on nails
 skips breakfast
 sensitive to lights/noise
 histrionic/argumentative
 likes spicy foods

Poor liver function
 sensitive to perfumes, chemicals, cigarettes
 headaches/migraines
 poor appetite

Gluten intolerance
 low iron
 loose, unformed stools
 abdominal bloating

floating stools
 itchy skin, psoriasis

Candida
 Thrush
 antibiotic use
 chronic congestion
 poor concentration
 bloating, gassiness
 sugar cravings
 eczema, psoriasis
 attention problems
 anal itching

Parasites
 abdominal bloating or discomfort
 food sensitivities
 tooth grinding
 psoriasis, eczema, hives
 fatigue
 anal itching
 loose/foul stools

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Do you have any dental amalgams? If so, how many?_____

Describe any other symptoms you would like us to know about you?

List any other history, pertinent thoughts or questions you want to address:
