CONFIDENTIAL PATIENT QUESTIONAIRE

Name: ______________________ Birthdate: ____________ Todays Date: ______________

Address: ____

City: ______________________ State: ________ Zip: __________

Home Phone: ( ) __________ Work Phone: ( ) __________ Best time to call: __________

Insurance Company: ______________________ Address: ______________________

Occupation: ______________________ Referred by: ______________________

Reason for coming: ____

How long has this been a concern? ____

Have you been treated for this before? ____

List any medications you are currently taking: ____

List any serious illnesses or surgeries you have had in your life (include ages): ____

____

List any known allergies to foods or drugs: ____

Any personal or family history of the following?

❍ Cancer	❍ Tuberculosis	❍ Diabetes	❍ Asthma
❍ Arthritis	❍ Epilepsy	❍ Heart disease	❍ Alcoholism
❍ Kidney disease	❍ High blood pressure	❍ Drug addiction	❍ Allergies
❍ Mental illness	❍ Other: ______________		

The following information will help determine a treatment most closely suited for you. Some of the questions may seem totally unrelated to your own situation, but please read each section carefully and place a check mark in the column which best describes how that symptom applies to you. If you do not know the answer to a question, leave it blank. Please answer all questions in each section even if they are asked more than once.

0 = Almost never (none) 1 = Sometimes (mild) 2 = Often (moderate) 3 = Most of the time (severe)

SECTION A	0	1	2	3
Stomach easily upset after eating	❍	❍	❍	❍
Bloating in stomach/upper abdomen	❍	❍	❍	❍
Burping or belching	❍	❍	❍	❍
Feeling of undigested food in stomach	❍	❍	❍	❍
Fullness in stomach after eating	❍	❍	❍	❍
Known or suspected food allergies?	Yes	❍	No	❍

SECTION B	0	1	2	3
Burning or gnawing stomach pain	❍	❍	❍	❍
Heartburn or indigestion	❍	❍	❍	❍
Stomach pain relieved by antacids	❍	❍	❍	❍
Stomach pain from stress or spicy foods	❍	❍	❍	❍
Wake at night with stomach pain	❍	❍	❍	❍
Stomach pain temporarily improved by eating	❍	❍	❍	❍
History of ulcer, gastritis, or antacid use	❍	❍	❍	❍
Nausea after eating	❍	❍	❍	❍

SECTION C	0	1	2	3
Abdominal bloating 1-3 hrs or after eating	❍	❍	❍	❍
Bloating in lower abdomen	❍	❍	❍	❍
Foul-smelling stools or gas	❍	❍	❍	❍
Shiny or loose, floating stools	❍	❍	❍	❍
Abdominal pain	❍	❍	❍	❍
Diarrhea	❍	❍	❍	❍
Difficulty gaining weight	❍	❍	❍	❍
Undigested food in stools	❍	❍	❍	❍

SECTION D	0	1	2	3
Constipation and/or diarrhea	❍	❍	❍	❍
Mucus or blood in stool	❍	❍	❍	❍
Joint pain or swelling, or arthritis	❍	❍	❍	❍
Chronic or frequent fatigue or tiredness	❍	❍	❍	❍
Food sensitivities or intolerance	❍	❍	❍	❍
Sinus or nasal congestion	❍	❍	❍	❍

SECTION D (continued)

	0	1	2	3
Eczema, skin rashes or hives (urticaria)	O	O	O	O
Asthma, hayfever, or airborne allergies	O	O	O	O
Confusion, poor memory, or mood swings	O	O	O	O
Use of non-steroidal anti-inflammatory drugs (e.g. aspirin)	O	O	O	O
Alcohol consumption	O	O	O	O
Have you used antibiotics in the past?	Yes O	No O		

SECTION E

	0	1	2	3
Dislike or intolerant of fatty foods	O	O	O	O
Headaches	O	O	O	O
Light-colored stools	O	O	O	O
Hard stools	O	O	O	O
Stiff joints or tendons	O	O	O	O
Short temper/mood swings	O	O	O	O
Cramps or twitching	O	O	O	O
Depression or apathy	O	O	O	O
Eye problems	O	O	O	O
Dizziness or vertigo	O	O	O	O
Pain or tenderness under right side of ribs	O	O	O	O
Elevated cholesterol or trigylcerides	O	O	O	O
Hemorrhoids	O	O	O	O

SECTION F

	0	1	2	3
Dry skin or hair, or brittle hair	O	O	O	O
Tiredness, low energy	O	O	O	O
Gain weight easily	O	O	O	O
Cold hands and/or feet	O	O	O	O
Sexual disinterest	O	O	O	O
Trouble concentrating or forgetful	O	O	O	O
Menstrual problems	O	O	O	O
Constipation	O	O	O	O
Headaches	O	O	O	O
Depression or apathy	O	O	O	O

SECTION G

	0	1	2	3
Dizziness on standing	O	O	O	O
Apprehension or fear	O	O	O	O
Weak or shaky feeling	O	O	O	O
Over-sensitive to sugar or sweet cravings	O	O	O	O
Hair falls out or is sparse	O	O	O	O
Impatient or irritable	O	O	O	O
Inability to concentrate	O	O	O	O
Scanty perspiration	O	O	O	O
Tiredness, low energy	O	O	O	O
Known or suspected allergies?	Yes O	No O		

SECTION H

	0	1	2	3
Catch colds or flu easily	O	O	O	O
Slow to recover from illness	O	O	O	O
Swollen lymph glands	O	O	O	O
Sore throat	O	O	O	O

SECTION H (continued)

	0	1	2	3
Runny nose	O	O	O	O
Recurrent infections	O	O	O	O
Cold sores or fever blisters	O	O	O	O
Easy bruising or bleeding gums	O	O	O	O
Skin bumps, boils or infections	O	O	O	O

SECTION I

	0	1	2	3
Itchy eyes, nose, ears, or roof of mouth	O	O	O	O
Painful or swollen joints or muscles	O	O	O	O
Fatigue especially after exertion	O	O	O	O
Post nasal drip	O	O	O	O
Skin rashes	O	O	O	O
Sneezing	O	O	O	O
Nasal or sinus congestion	O	O	O	O
Dark circles under eyes	O	O	O	O
Ears stuffed up	O	O	O	O
Feel worse after eating certain foods	O	O	O	O
Wheezing/asthma	O	O	O	O
Non-restorative sleep	O	O	O	O
Low-grade fever	O	O	O	O

SECTION J

	0	1	2	3
Irritable, weak, or shaky if meal is missed	O	O	O	O
Headaches relieved by eating	O	O	O	O
Heart races after eating sugar	O	O	O	O
Feel tired 1-3 hours after eating	O	O	O	O
Feel faint easily	O	O	O	O
Dizziness on standing	O	O	O	O
Need coffee for energy	O	O	O	O
Craves sweets	O	O	O	O
Periods of emotional instability	O	O	O	O

SECTION K

	0	1	2	3
Increased thirst	O	O	O	O
Increased urination	O	O	O	O
Night sweats	O	O	O	O
Overweight	O	O	O	O
Yeast infections	O	O	O	O
Lowered resistance to infections	O	O	O	O
Wounds heal slowly	O	O	O	O
Family history of diabetes?	Yes O	No O		

SECTION L

	0	1	2	3
Chest pain during exertion	O	O	O	O
Heaviness in legs	O	O	O	O
Heart misses beats or races	O	O	O	O
Swelling of feet or ankles	O	O	O	O
Difficulty breathing at night	O	O	O	O
Fatigue after minor exertion	O	O	O	O
Insomnia	O	O	O	O
Nightmares	O	O	O	O
Poor circulation	O	O	O	O

SECTION M

	0	1	2	3
Difficult or painful breathing	○	○	○	○
Chronic cough	○	○	○	○
Cough up phlegm	○	○	○	○
Recurrent respiratory infections	○	○	○	○
Shortness of breath	○	○	○	○
Heavy feeling or tightness in chest	○	○	○	○
Very dry skin	○	○	○	○
Runny or stuffy nose	○	○	○	○
Nose bleeds	○	○	○	○

SECTION N

	0	1	2	3
Frequent urination	○	○	○	○
Difficulty urinating	○	○	○	○
Painful urination	○	○	○	○
Cloudy, red, or brownish urine	○	○	○	○
Strong smelling urine	○	○	○	○
Pain in mid to lower back	○	○	○	○
Water retention or ankle swelling	○	○	○	○
Recurrent bladder or kidney infections	○	○	○	○
Urinary leakage or incontinence	○	○	○	○
Ringing in ears	○	○	○	○
Weak knees	○	○	○	○
Night time urination	○	○	○	○
Aversion to cold	○	○	○	○
Sexual disinterest	○	○	○	○
Night sweats	○	○	○	○
Cold hands/feet	○	○	○	○

SECTION O

	0	1	2	3
Bone fractures	○	○	○	○
Leg cramps at night	○	○	○	○
Muscle spasms or cramps	○	○	○	○
Back pain	○	○	○	○
Bursitis or tendonitis	○	○	○	○
Stiff, painful or swollen joints	○	○	○	○
Stiff all over	○	○	○	○
Pain in neck and/or shoulders	○	○	○	○

Known or suspected osteoporosis? Yes ○ No ○

SECTION P (Women only)

	0	1	2	3
a) Symptoms within 2 weeks before period:				
Weight gain	○	○	○	○
Depression or irritability	○	○	○	○
Sore or swollen breasts	○	○	○	○
Abdominal bloating or swelling	○	○	○	○
Low back ache	○	○	○	○
Crave sweets	○	○	○	○
Headaches	○	○	○	○
b) General symptoms:				
Vaginal itching	○	○	○	○
Vaginal discharge	○	○	○	○
Irregular or missed periods	○	○	○	○
Heavy bleeding during period	○	○	○	○
Light bleeding during period	○	○	○	○
Bleeding during mid-cycle	○	○	○	○
Clotting during period	○	○	○	○
Cramps/painful menses	○	○	○	○
Pelvic inflammatory disease	○	○	○	○
Ovarian cysts or uterine fibroids	○	○	○	○
Herpes, genital	○	○	○	○

c) General information:

Number of pregnancies: ______

Number of children born: ______

Caesarians: ______

Miscarriages: ______

Abortions: ______

Age at onset of menses: ______

Number of days between bleeding: ______

Number of days of flow: ______

Light ○ Moderate ○ Heavy ○

Ever use an IUD? Yes ○ No ○

Ever use the pill? Yes ○ No ○

Number of years: ______

d) Menopausal or pre-menopausal symptoms:

	0	1	2	3
Hot flashes	○	○	○	○
Mood swings	○	○	○	○
Insomnia	○	○	○	○
Erratic or missed periods	○	○	○	○
Dryness of skin, hair, vagina	○	○	○	○
Painful intercourse	○	○	○	○

SECTION Q (Men only)

	0	1	2	3
Difficult urination	○	○	○	○
Painful urination	○	○	○	○
Dribbling after urination	○	○	○	○
Painful or premature ejaculation	○	○	○	○
Sexual disinterest	○	○	○	○
Uncomfortable feeling of bladder fullness	○	○	○	○
Impotence	○	○	○	○
Herpes, genital	○	○	○	○

SECTION R

	0	1	2	3
Aching in bones	○	○	○	○
Aching in back	○	○	○	○
Fracture of vertebrae or hip/brittle bones	○	○	○	○
High protein diet	○	○	○	○
Eat processed, refined, or convenience packaged foods	○	○	○	○
Drink carbonated beverages	○	○	○	○
Drink coffee	○	○	○	○
Smoking	○	○	○	○
Salt in diet	○	○	○	○
Fat in diet	○	○	○	○
Sugar in diet	○	○	○	○
Excessive stress	○	○	○	○
Physical inactivity	○	○	○	○