File Number____________

PATIENT INFORMATION

First Name: _________________________ Last Name:___________________________

Address:____

City: _____________________________ Postal Code: ____________________________

How did you discover us? ____

Birthdate: (Day/Month/Year)____/____/____Age: _________ Gender: ☐ F ☐ M

Home Phone: ___________________ Evening Phone: ____________________

Cell Phone:____________________

Email Address: ____
(Note: Your e-mail address, as well as all other personal information, will remain private and will be used for in-office purposes only)

Occupation: ____

HEALTH AND LIFESTYLE OVERVIEW

Please take some time to answer the following questionnaire.

Describe what is bothering you. If this involves a specific health condition or illness, please tell me about it in as much detail as possible. List the very first time you noticed the condition and describe carefully any factors that you think may have played a role in its onset and progression. (Please attach a sheet of paper if more space is required).

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Is your health currently getting better, worse, or staying the same? How do you know?

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What have you tried to do to improve your state of health (ex: other doctors, treatments, etc)?

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Please list the five most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

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

Please list any other health concerns/conditions, even if you think they may not be important.

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Why did you choose my clinic?

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For our time together to be a true win for you, what do you want to take place over the course of your care here?

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How long do you feel this will take?

____
____

Do you think the pain and/or symptoms that you are experiencing could be purposeful? That is, could they be your body's wisdom saying, "I need some help…let's change some things here!" Please explain:

____
____
____

Do you feel your pain and/or illness is a reflection of short-term superficial circumstances or longer-term potentially deeper-seated challenges?

____
____

What areas of your life are likely involved with your condition and you would like to improve: (prioritize #1, 2, 3, etc.)

___My diet and nutrition program
___Not enough quiet time and rest
___Not enough time spent in nature
___My creative expression
___My social and family life
___My level of anxiety
___My pace of living
___My exercise program
___My feelings around career
___My communication skills

Please list any self-destructive lifestyle habits (ex: smoking, lack of exercise, addictions, etc.)

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How might it affect you if you don't significantly improve your lifestyle and any underlying contributors to compromised health? (For example: vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

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What is your present level of commitment to change the underlying causes of problem(s) which relate to your lifestyle? (Rate from 1 to 10, with 10 being 100% committed).

____
____

List your three highest priorities in life which come to mind and speak to your heart. Where does your health and vitality factor in?

1.____
2.____

3.____

What obstacles could prevent you from changing those lifestyle factors that are undermining your health?

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What might stop you from following the therapeutic protocols that I may prescribe for you?

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Who would be willing to support you in your health goals?

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Please list your special interests and passions:

____
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Please circle the appropriate number "0 – 3" on all questions below.
0 as the least/never to 3 as the most/always

Feel that bowels do not empty completely	0 1 2 3	Greasy or high fat foods cause distress	0 1 2 3
Lower abdominal pain relief by passing stool or gas	0 1 2 3	Lower bowel gas and/or bloating several hours after eating	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3	Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Diarrhea	0 1 2 3		
Constipation	0 1 2 3	Unexplained itchy skin	0 1 2 3
Hard, dry or small stool	0 1 2 3	Yellowish cast to eyes	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3	Stool color alternated from clay colored to normal brown	0 1 2 3
Pass large amounts of foul smelling gas	0 1 2 3		
More that 3 bowel movements daily	0 1 2 3	Reddened skin, especially palms	0 1 2 3
Do you use laxatives frequently	0 1 2 3	Dry or flaky skin and/or hair	0 1 2 3
		History of gallbladder attacks or stones	0 1 2 3
		Have you had your gallbladder removed?	Yes No
Excessive belching, burping or bloating	0 1 2 3		

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Gas immediately following a meal	0 1 2 3		
Offensive breath	0 1 2 3	Crave sweets during the day	0 1 2 3
Difficult bowel movements	0 1 2 3	Irritable if meals are missed	0 1 2 3
Sense of fullness during and after meals	0 1 2 3	Depend on coffee to keep yourself going or started	0 1 2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools	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
Stomach pain, burning or aching 1-4 hours after eating	0 1 2 3	Agitated, easily upset, nervous	0 1 2 3
		Poor memory, forgetful	0 1 2 3
Do you frequently use antacids?	0 1 2 3	Blurred vision	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	Fatigue after meals	0 1 2 3
		Crave sweets during the day	0 1 2 3
Temporary relief from antacids, food, milk, carbonated beverages	0 1 2 3	Eating sweets does not relieve cravings for sugar	0 1 2 3
Digestive problems subside with rest and relaxation	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
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0 1 2 3	Frequent urination	0 1 2 3
		Increased thirst and appetite	0 1 2 3
		Difficulty losing weight	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	Cannot stay asleep	0 1 2 3
		Crave salt	0 1 2 3
Pain, tenderness, soreness on left side under rib cage bloated	0 1 2 3	Slow starter in the morning	0 1 2 3
		Afternoon fatigue	0 1 2 3
Excessive passage of gas	0 1 2 3	Dizziness when standing up quickly	0 1 2 3
Nausea and/or vomiting	0 1 2 3	Afternoon headaches	0 1 2 3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0 1 2 3	Headaches with exertion or stress	0 1 2 3
		Weak nails	0 1 2 3
Frequent urination	0 1 2 3		
Increased thirst and appetite	0 1 2 3		
Difficulty losing weight	0 1 2 3		

Please circle the appropriate number "0 – 3" on all questions below.
0 as the least/never to 3 as the most/always

Cannot fall asleep	0 1 2 3	Males Only	
Perspire easily	0 1 2 3	Decrease in libido	0 1 2 3
Under high amounts of stress	0 1 2 3	Decrease in spontaneous morning erections	0 1 2 3
Weight gain when under stress	0 1 2 3	Decrease in fullness of erections	0 1 2 3
		Difficulty in maintaining morning erections	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3	Spells of mental fatigue	0 1 2 3
		Inability to concentrate	0 1 2 3
Excessive perspiration or perspiration with little or no activity	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
Tired, sluggish	0 1 2 3	Unexplained weight gain	0 1 2 3
Feel cold – hands, feet, all over	0 1 2 3	Increase in fat distribution around chest and hips	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3	Sweating attacks	0 1 2 3
Increase in weight gain even with low calorie diet	0 1 2 3	More emotional than in the past	0 1 2 3
Gain weight easily	0 1 2 3		

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Difficult, infrequent bowel movements	0 1 2 3	Menstruating Females Only	
Depression, lack of motivation	0 1 2 3	Are you menopausal?	Yes No
Morning headaches that wear off as the day progresses	0 1 2 3	Alternating menstrual cycle lengths?	Yes No
Outer third of eyebrow thins	0 1 2 3	Extended menstrual cycle, greater than 32 days	Yes No
Thinning of hair on scalp, face or genitals or excessive falling hair	0 1 2 3	Shortened menses, less than every 24 days	Yes No
Dryness of skin and/or scalp	0 1 2 3	Pain and cramping during periods	0 1 2 3
Mental sluggishness	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
Heart palpitations	0 1 2 3	Acne break outs	0 1 2 3
Inward trembling	0 1 2 3	Facial hair growth	0 1 2 3
Increased pulse even at rest	0 1 2 3	Hair loss/thinning	0 1 2 3
Nervous and emotional	0 1 2 3		
Insomnia	0 1 2 3		
Night sweats	0 1 2 3	Menopausal Females Only	
Difficulty gaining weight	0 1 2 3	How many years have you been menopausal?	
Diminished sex drive	0 1 2 3	Do you ever have uterine bleeding since menopause?	Yes No
Menstrual disorders or lack of menstruation	0 1 2 3	Hot flashes	0 1 2 3
		Mental fogginess	0 1 2 3
Increased ability to eat sugars without symptoms	0 1 2 3	Disinterest in sex	0 1 2 3
		Mood swings	0 1 2 3
		Depression	0 1 2 3
Increased sex drive	0 1 2 3	Painful intercourse	0 1 2 3
Tolerance to sugars reduced	0 1 2 3	Shrinking breasts	0 1 2 3
"Splitting" type headaches	0 1 2 3	Facial hair growth	0 1 2 3
		Acne	0 1 2 3
		Increased vaginal pain, dryness or itching	0 1 2 3
Males Only			
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	0 1 2 3		