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ADULT MEDICAL QUESTIONNAIRE

My ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance my efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist to formulate a treatment plan.

First Name: ____________________ Middle Name: ______________ Last Name: _________________________

Address: __________________________ City: ______________________ State: ______ Zip: ________________

Cell/Mobile: ________________________ Birth Date: _____/_____/_____ Age: _________
month day year

Work Phone: _______________________ Best Email: _______________________________________

Place of Birth: ___________________________ Occupation: ______________________________________

Sex: _______ Height: ____’______” Present Weight: ______________

Weight History:
Highest Adult Weight: ______________ Lowest Adult Weight: __________________

Referred By: __________________________________ Today’s Date: ___________________________

Why Are You Here?

1. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/MODERATE/SEVERE	TREATMENT APPROACH	SUCCESS
Example: Postnasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

2. Have you lived or traveled outside the United State? Yes _______ No _______

3. Have you or your family recently experienced any major life changes? Yes _______ No _______

4. Have you experience any major losses in life? Yes _______ No _______

5. Do you consider religion or spirituality important for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

6. How much time have you lost from work or school in the past year?

a. _____ 0-2 days b. _____ 3-14 days c. _____ >15 days

7. Previous jobs:

____

____

____

8. Unfortunately, witnessing or experience abuse and violence of all kinds (verbal, mental, emotional, physical, and sexual) are leading contributors in chronic stress, illness, and immune system dysfunction. If you are currently experiencing or witnessing or have in the past experienced or witnessed any kind of abuse, it is important that you feel safe telling me about it so I can support you and optimize your treatment.

Please do your best to answer the following questions:
a. Did you feel safe growing up? Yes _______ No _______

b. Do you feel safe now? Yes _______ No _______

c. Have you been involved in abusive relationships in your life? Yes _______ No _______

d. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships? Yes _______ No _______

e. Do you feel safe, respected, and valued in your current relationship? Yes _______ No _______

f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse? Yes _______ No _______

9. Past Medical and Surgical History:

ILLNESSES	APPROXIMATE YEAR	STILL AN ISSUE?
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn’s Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, convulsions, or seizures		
k. Gallstones		
l. Gout		
m. Heart attack/Angina		
n. Heart failure		
o. Hepatitis		
p. High blood fats (cholesterol, triglycerides)		
q. High blood pressure (hypertension)		
r. Irritable bowel		
s. Kidney stones		
t. Mononucleosis		
u. Pneumonia		
v. Rheumatic fever		
w. Sinusitis		
x. Sleep apnea		
y. Stroke		
z. Thyroid disease		
aa. Other (describe)		
INJURIES	**APPROXIMATE YEAR**	**STILL AN ISSUE?**
ab. Back injury		
ac. Broken (describe)		
ad. Head injury		
ae. Neck injury		
af. Other (describe)		

DIAGNOSTIC STUDIES	APPROXIMATE YEAR	COMMENTS
ag. Barium Enema		
ah. Bone seam		
ai. CAT Scan of Abdomen		
aj. CAT Scan of Brain		
ak. CAT Scan of Spine		
al. Chest X-ray		
am. Colonoscopy		
an. EKG		
ao. Liver scan		
ap. Neck X-ray		
aq. NMR/MRI		
ar. Sigmoidoscopy		
as. Upper GI Series		
at. Other (describe)		
OPERATIONS	**APPROXIMATE YEAR**	**COMMENTS**
au. Appendectomy		
av. Dental Surgery		
aw. Gall Bladder		
ax. Hernia		
ay. Hysterectomy		
az. Tonsillectomy		
ba. Other (describe)		
bb. Other (describe)		

10. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

11. Childhood:

Were you a full term baby? Yes _______ No _______ Comments _________________________________

a. Did you have a vaginal or C-section delivery? Vaginal _______ C-section _______

Comments________________________________

b. Were you a preemie? Yes _______ No _______ Comments ________________________________

c. Were you Breast fed _______ Bottle fed _______ Comments ______________________________

12.

a. As a child were there any foods that you had to avoid because they gave you symptoms? Yes ____ No ____

If yes, please name the foods and symptoms (Example: milk – gas and diarrhea) ____________________

____

b. As a child did you eat a lot of sugar and/or candy Yes _______ No _______

Comments ____

13. How often have you taken antibiotics?

Infancy/Childhood <5 times _______ >5 times _______

Teen <5 times _______ >5 times _______

Adulthood <5 times _______ >5 times _______

14. How often have you taken oral steroids (e.g. Cortisone, Prednisone, etc.)?

Infancy/Childhood <5 times _______ >5 times _______

Teen <5 times _______ >5 times _______

Adulthood <5 times _______ >5 times _______

15. a. Are you on a special diet? Yes _______ No _______ If so, please describe: _______________________

____

b. How did you choose this diet? ____

16. Is there anything special about your diet that I should know? Yes _______ No _______

If yes, please explain: ____

____

17. a. Do you have symptoms **<u>immediately after</u>** eating, such as belching, bloating, sneezing, hives, etc.?

Yes _______ No _______

b. If yes, are these symptoms associated with any particular food or supplement(s)?

Yes _______ No _______

c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

____

____

18. Do you feel you have **<u>delayed</u>** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes _______ No _______

19. Do you feel much worse when you eat:

____ high fat foods ____ refined sugar (junk food)

____ high protein foods ____ fried foods

____ high carbohydrate foods (breads, pastas, potatoes) ____ 1 or 2 alcoholic dinks

____ Skip Meals Other ______________________________

20. Do you feel much better when you eat certain foods? Yes _______ No _______

21. Have you ever had a food that you craved or really "binged" on over a period of time?
Food cravings may be an indicator that you may be allergic to that food Yes _______ No _______

If yes, what food(s)? ____

____

22. Do you have an aversion to certain foods?   Yes _______   No _______

If yes, what foods and why? ____

____

23. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	c. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed			
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

24. Intestinal gas:

____ Daily   ____ Present with pain

____ Occasionally   ____ Foul smelling

____ Excessive   ____ Little odor

25. a. Have you ever used alcohol?   Yes _______   No _______

b. If yes, how often do you **now** drink alcohol?

____ No longer drinking alcohol   ____ Average 1-3 drinks/ week

____ Average 4-6 drinks/week   ____ Average 7-10 drink/week

____ Average >10 drinks/week

c. Have you ever had a problem with alcohol?   Yes _______   No _______

26. Have you ever used recreational drugs? Yes _______ No _______

27. Have you ever used tobacco? Yes _______ No _______

Amount per day ____ Year quit ____

____ Cigarette ____ Smokeless ____ Cigar ____ Pipe ____ Patch/Gum

28. Are you exposed to secondhand smoke regularly? Yes _______ No _______

29. Do you have mercury amalgam fillings (silver fillings)? Yes _______ No _______

30. Do you have any artificial joints or implants (including Botox)? Yes _______ No _______

31. Do you feel worse at certain times of the year? Yes _______ No _______

If yes, when? Spring _______ Summer _______ Fall _______ Winter _______

32. Have you, to your knowledge, been exposed to toxic metals or mold in your job or at home?

Yes _______ No _______

If yes, which one(s)? Lead _______ Cadmium _______ Arsenic _______ Mercury _______

Aluminum _______ Mold _______

33. Do odors affect you? Yes _______ No _______

34. How well have things been going for you?

	Very Well	**Fair**	**Poorly**	**Very Poorly**	**Does not apply**
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

35. Have you ever had psychotherapy or counseling? Yes _______ No _______

Currently? Yes _______ No _______ If yes, with who? _______________________________

36. Are you currently, or have you ever been, married? Yes _______ No _______

If so, when were you married? _________ Spouse's Occupation: ______________________________

If you are divorced or separated:

When were you separated? __________ Never ______

When were you divorced? ___________ Never ______

When were you remarried? _________ Never ______ Spouse's Occupation: ________________

37. Hobbies and leisure activities: ____

____

38. Do you exercise regularly? Yes _______ No _______
If so, how many times a week?

1x ____ 2x ____ 3x ____ 4x or more ____

When you exercise, how long is each session?

≤15 minutes ____ 16-30 minutes ____ 31-45 minutes____ >45 minutes ____

What type of exercise is it? Cardio ____ Yoga ____ Low Impact ____ Weight Training ____

39. **FAMILY HISTORY**: For each member of your family, fill in the charts below accordingly.
a) Their present state of health

Family members' name	Good Health	Poor Health	Deceased	Age and cause of death (include accidents and suicide)
Father:				
Mother:				
Sibling 1:				
Sibling 2:				
Sibling 3:				
Sibling 4:				
Spouse:				
Child 1:				
Child 2:				
Child 3:				
Child 4:				

b) Check the box according to any illnesses your family members' have had. For the Paternal and Maternal relatives write how many of each are affected with each condition.

Relative	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Dis	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer
Father															
Mother															
Sibling 1															
Sibling 2															
Sibling 3															
Sibling 4															
Spouse															
Child 1															
Child 2															
Child 3															
Child 4															
Paternal Relatives															
Maternal Relatives															

40. Any other family medical history I should know about? Yes _______ No _______

If so, please comment: ____

41. What is the attitude of those close to you about your illness? Supportive _____ Non-supportive _____

42. What medications are you taking now? Include non-prescription drugs.

Medication Name	Date Started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Are you allergic to any medications? Yes _______ No _______

If yes, please list: ____

43. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date Started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

44. Please make a check mark next to the food/drink that applies to your current diet. (List continues on next page)

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other (List below)		x.	Yellow vegetables	
						y.	Other (List below)	

45. How much of the following do you consume each week?

a. Candy	
b. Cheese	
c. Chocolate	
d. Cups of coffee containing caffeine	
e. Cups of decaffeinated coffee or tea	
f. Cups of hot chocolate	
g. Cups of tea containing caffeine	
h. Diet sodas	
i. Ice cream	
j. Salty foods	
k. Slices of white bread (rolls/bagels)	
l. Sodas with caffeine	
m. Sodas without caffeine	

FOR WOMEN ONLY (questions 46-54)

46. Have you ever been pregnant? (If no, skip to question 47) Yes _______ No _______

Number of miscarriages _______ Number of abortions _______ Number of preemies _______

Number of term births _______ Birth weight of largest baby _______ Smallest baby _______

Did you develop toxemia (high blood pressure) or gestational diabetes? Yes _______ No _______

Have you had other problems with pregnancy? Yes _______ No _______

If so, please comment: ____

____

47. Age at first period _______ Date of last Pap Smear _______ Date of last Mammogram _______

48. Have you ever used birth control pills? Yes _______ No _______ If yes, when _______

49. Are you taking the pill now? Yes _______ No _______

50. Did taking the pill agree with you? Yes _______ No _______ Not applicable _______

51. Do you currently use contraception? Yes _______ No _______

If yes, what type of contraception do you use? ____

52. Are you in menopause? Yes _______ No _______ If yes, age of last period _______

53. Do you take any take any type of hormone replacement? Yes _______ No _______

If yes, what type and for how long? ____

54. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes _______ No _______ Not applicable _______