GENERAL INFORMATION

Name _____Preferred Name_____ Date _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Age ___ Date of Birth _____ Gender: Female ___ Male___ Referred by? _____

Preferred time for consultations: ___ AM ___PM M T W TH F (please circle)

Number of Sisters: ____ (# deceased: ____) # of Brothers: ____ (# deceased: ____)

Occupation _____ Hours worked per week _____ Retired _____

In case of emergency, contact _____ Phone _____

Who is your primary medical physician?_____ Address & office phone # _____

PERSONAL DESCRIPTIVE INFORMATION

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)

Example: Wendy, age 7, sister

_____

Do you have any pets or farm animals? Yes____ No____

If yes, where do they live? Indoors_____ Outdoors _____

Have you or your family recently experienced any major life changes? Yes____ No____

Comment: _____

Have you experienced any major losses in life? Yes____ No____

Comment: _____

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

_____ 0-2 days	_____ 3 –14 days	_____ > 15 days

Level of education: _____

Functional Diagnosis Questionnaire

Please complete the following questionnaire to the best of your ability. Your thoroughness and accuracy in answering all appropriate questions will help evaluate the root cause of your health concerns and determine an effective treatment program.

COMPLAINTS/CONCERNS	

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe

What diagnosis or explanation has been given to you?_____

_____

_____

When was the last time you felt well? _____

Did something trigger your changes in health? _____

_____

What makes you feel **worse**? _____

What makes you feel **better**? _____

Please list all physicians you have seen for the above health conditions:

1.	4.
2.	5.
3.	6.

PAST MEDICAL & SURGICAL HISTORY

ILLNESSES	Date	Date	Date	Comments
Chicken pox				
German measles				
Measles				
Mononucleosis				
Mumps				
Whooping cough				
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic fatigue				
Crohn's disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				
Heart attack/angina				
Heart failure				
Hepatitis				
High blood pressure				
Irritable bowel				

Kidney stones				
Mononucleosis				
Pneumonia				
Rheumatic fever				
Sinusitis				
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				
Head injury				
Neck injury				
Back injury				
Fracture				
Other (describe)				
Other (describe)				
DIAGNOSTIC STUDIES	**Date**	**Date**	**Date**	**Comments**
Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy				
Colonoscopy				
Upper GI series				
Barium enema				
CAT scan of abdomen				
CAT scan of brain				
CAT scan of spine				
Liver scan				

Bone scan				
Neck X-rays				
Back X-rays				
MRI				
Bone density test				
Carotid artery ultra-sound				
Other (describe)				
OPERATIONS	**Date**	**Date**	**Date**	**Comments**
Tonsillectomy				
Tubes in ears				
Appendectomy				
Gall bladder				
Hernia				
Hysterectomy				
Dental surgery				
Other (describe)				
Other (describe)				

HOSPITALIZATIONS

Hospitalized Where?	When	For What Reason

FEMALE MEDICAL HISTORY (for women only)

OBSTETRICS HISTORY *Check box if yes and provide number of*

❑ Pregnancies _____	❑ Caesarean _____	❑ Vaginal deliveries _____
❑ Miscarriage _____	❑ Abortion _____	❑ Living Children _____
❑ Post partum depression	❑ Toxemia	❑ Gestational diabetes
❑ Baby over 8 pounds	❑ Breast feeding For how long?_____	

GYNECOLOGICAL HISTORY

Age at 1st period:_____	Menses Frequency: _____	Length: _____	Pain: Yes____ No ____
Clotting: Yes ___ No ___ Has your period skipped? ____ For how long? ____			
Do you currently use contraception? Yes _____ No _____ If yes, what type do you use?			
In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?		❑ Yes	❑ No
Last Mammogram _____ Breast Biopsy/Date _____ Last PAP Test: _____			
Date of last Bone Density: _____ Results:	_____		
Are you in menopause? Yes _____ No _____ Age at Menopause _____			

Do you take:	❑ Estrogen	❑ Provera	❑ Estrace	❑ Premarin	Other _____
	❑ Progesterone		Other _____		

How long have you been on hormone replacement therapy?
_____

FAMILY HISTORY

(Mark any health problem(s) your family has suffered either now or in the past)

Check Family Members that Apply	Father	Mother	Sib-lings	Chil-dren	Grand-mother	Grandfa-ther
Age (if still alive)						
Age at death (if deceased)						
ADD/ADHD						
ALS or Neurological diseases						
Alzheimer's						
Anemia						
Anxiety						
Arthritis						
Asthma						
Autism						
Autoimmune diseases Lupus etc.						
Bipolar disease						
Bladder disease						
Blood clotting problems						
Cancer						
Celiac disease						
Dementia						
Depression						
Diabetes						
Eczema						
Emphysema						
Environmental sensitivities						
Epilepsy						

Flu						
Check Family Members that Apply	**Father**	**Mother**	**Sib-lings**	**Chil-dren**	**Grand-mother**	**Grandfa-ther**
Food Allergies, sensitivities						
Genetic disorders						
Glaucoma						
Headache						
Heart attack						
Heart Disease						
High blood pressure						
High cholesterol						
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)						
Inflammatory bowel disease						
Insomnia						
Irritable bowel syndrome						
Kidney disease						
Multiple sclerosis						
Obesity						
Osteoporosis						
Parkinson's						
Pneumonia/bronchitis						
Psoriasis						
Psychiatric disorders						
Schizophrenia						
Sleep Apnea						
Smoking addiction						
Stroke						
Substance abuse (such as alcohol-ism)						

Thyroid Disease						
Ulcers						

Any other family history I should know about? Yes ___ No ___ Comment: _____

ESTABLISHING HEALTH GOALS

What do you hope to achieve? _____

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

Have you made the decision to change? To do what it takes to get well? Yes___ No___

List up to 3 things that you have been unable to do as a result of your present symptoms.

1._____
2._____
3._____

List up to 3 things that you plan to do once you are feeling better. Please be specific. (Use extra pages if necessary)

1._____
2._____
3._____

DENTAL HISTORY

Have you had sore gums (gingivitis) often over the years? Yes ____ No _____

Have TMJ problems been a concern? Yes ____ No _____

Do you often have a 'metallic' taste in your mouth? Yes ____ No _____

Do you have bad breath or white tongue (thrush)? Yes ____ No _____

Have you worn wear braces? Yes ____ No _____

Do you have problems chewing? Yes ____ No _____

Did your mother have amalgam fillings prior to birth to you? Yes ____ No _____

Do you have silver fillings? How many? _____ Yes ____ No _____

Did you play with mercury as a child or adult? Yes ____ No _____

Do you have implants? How many? _____ Yes ____ No _____

Do you have root canals? How many? _____ Yes ____ No _____

Do you have crowns and bridges? How many? _____ Yes ____ No _____

MEDICATIONS/SUPPLEMENTS

Antibiotics: How often have you taken antibiotics?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

MEDICATION LOG

Please indicate the type of prescription or non-prescription medications you are taking now.

Medication Name	Date started	Dated Stopped	Dosage	# per day

SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name/Brand	Dose	Frequency	Dated Started	Reason for use

NUTRITION & LIFESTYLE HISTORY

Have you made any changes in your eating habits because of your health? Yes____ No_____
Do you currently follow a special diet or nutritional program? Yes____ No_____
How would you describe your overall diet? _____
What types of diets have you followed in the past? _____
Please circle any specific food restrictions you have: Dairy Soy Wheat Corn Eggs Gluten

Height:_____ Current Weight: _____ How often do you weigh yourself? _____

If you could only eat a few foods a week, what would they be? _____

Do you grocery shop? Yes _____ No _____ If no, who does the shopping? _____

Do you cook? Yes _____ No _____ If no, who does the cooking? _____

How many meals do you eat out per week? 0-1_____ 1-3____ 3-5____ >5_____

Do you have an aversion to certain foods? Yes _____ No _____ What?_____

What snacks do you eat or drink between meals?_____

SUBSTANCE HISTORY

TOBACCO HISTORY

Currently using tobacco? Yes _____ No _____ How many years? _____ Packs per day: _____
If yes, what type? Cigarette _____ Smokeless _____ Cigar _____ Pipe _____ Patch/Gum _____
Previous smoking: How many years? _____ Packs per day: _____
Are you exposed to 2nd hand smoke? If yes, please explain: _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits*

None _____ 1-3 _____ 4-6 _____ 7-10 _____ >10 _____ *If none skip to "Other Substances"*

Previous alcohol intake? Yes ____ (Mild _____ Moderate _____ High _____)

Do you ever feel guilty about your alcohol consumption? Yes____ No____

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes____ No____

Have you ever been unable to remember what a drinking episode? Yes____ No____

Have you ever been arrested or hospitalized because of drinking? Yes____ No____

Have you ever thought about getting help to control or stop your drinking? Yes____ No____

Any family members alcoholics? Mother _____ Father _____ Other family member _____

OTHER

Are you currently using recreational drugs? Yes____ No____ If yes, what? _____

EXERCISE

Please describe your current exercise program. List the activity, number of sessions/week and duration of activity. _____

ALLERGIES ___ Pollen ___ Dust ___ Other _____

SLEEP ___ Normal ___ Difficulty ___ # hours/night

URINE/FREQUENCY ___ # times per day

BOWELS ___ # per day Consistency: ___ soft ___ hard___loose ___ other
Color: ___light brown ___dark brown ___green ___black ___other

HOBBIES _____

TOXIC EXPOSURES _____

WATER ____ # ounces of water per/day Type: ___tap___distilled___well___RO