

Initial Questionnaire

New Patient Registration

Name: _____

Mailing Address: _____

City: _____

State: _____ **Zip:** _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email address: _____

Age: _____ **Birthdate:** _____ **Sex:** _____

Occupation: _____

Education: _____

Relationship Status: _____

Religious Outlook: _____

How did you learn about this office?

Name of primary care physician or clinic, if any:

Name(s) of other health or mental health care providers:

Please indicate the following:

Mother's name: _____ Date of Birth: _____

Father's name: _____ Date of Birth: _____

Initial Questionnaire

Health History

Please check **any** you have ever had:

- concussion
- fainting
- headaches
- migraines
- anxiety
- depression
- mood swings
- alcohol abuse
- drug abuse
- numbness
- dizziness
- sweats
- chills
- sleep loss
- weight loss

- eye problems
- flashes in vision
- halos in vision
- blurred vision
- crossed eyes

- TMJ
- ringing in ears
- hearing loss
- earache
- ear discharge
- hay fever
- hoarseness
- sinus problems
- nasal polyps
- thyroid problems

- bruise easily
- hives
- rashes
- itching
- change in moles
- scars
- unhealed sores
- difficult breathing

- muscle pain
- muscle weakness
- numbness
- tingling
- joint pain
- swollen joints

- asthma
- pneumonia
- bronchitis
- pleurisy
- chest pain
- high BP
- irregular heart beat
- low BP
- poor circulation
- rapid heart beat
- swollen ankles
- varicose veins

- bleeding gums
- sores on gums
- difficulty swallowing
- poor appetite
- bloating
- bowel changes
- constipation
- diarrhea
- excess hunger
- excess thirst
- gas
- hemorrhoids
- rectal bleeding

- indigestion
- acid reflux
- nausea
- stomach pain
- vomiting
- vomiting blood
- stomach ulcer
- IBS
- colon polyps

- blood in urine
- frequent urination
- leaky bladder
- painful urination

For Men:

- breast lump
- ED
- lump in testicles
- penis discharge
- sore on penis
- gonorrhea
- syphilis
- chlamydia
- warts

For Women:

- abnormal Pap
- breast lump
- hot flashes
- nipple discharge
- painful intercourse
- vaginal discharge
- spotting
- extreme cramps
- gonorrhea
- syphilis
- chlamydia
- HPV

Initial Questionnaire

Serious Illnesses/Injuries:

What?	When?
_____	_____
_____	_____
_____	_____
_____	_____

Pregnancy History:

Child	Any Complications?	Born when?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Habits: How much? How often?

Caffeine	_____	_____
Tobacco	_____	_____
Rec drugs	_____	_____
Other	_____	_____

Hospitalizations:

For what reason?	Hospital?	When?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Occupational concerns:

___ Work stress

___ Exposure to Hazardous materials

___ Heavy Lifting

___ Long sitting

Family History:

Family	Year of Birth	Year of Death	Cause of Death	History of Health Problems
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Initial Questionnaire

6. In general, are you a chilly person or a hot person? Or somewhere in between?
Chilly people often feel cold and carry warm clothing with them should they get a chill. Warmer people often feel uncomfortable in a warm room or in hot weather and may wear less clothing than others all year round.

7. Does a particular part of your body get especially hot or cold at any time of the day or night? Or in special circumstances?

8. In general, are you sensitive to or strongly affected by the various seasons of the year? Or the change of seasons?

9. Are you sensitive to or strongly affect by any weather or climate condition including: hot weather, cold winds, wet days, sun exposure, cloudy days, fog, snow, cool breezes etc.?

10. Is there a natural environment that you prefer or feel relief from? Do the mountains, the desert, the seashore affect you?

11. Are you affected by open air or drafts of air or stuffy rooms? In what way?

Initial Questionnaire

12. What times of day do you feel most energetic?

13. What times of day do you feel most tired?

14. What time of day are your symptoms most troublesome?

15. What kind of exercise or activities do you enjoy participating in? *For example: walking, hiking, horseback riding, car racing, winter sports, summer sports, yoga, parties, dancing, meditation, chanting etc.?* Do you feel better or worse from physical exertion or exercising?

16. Do you perspire? Do you perspire on a particular part of your body? Do you perspire most at a particular time of day or in a particular situation?

17. Does snug fitting clothing, such as turtlenecks, watchbands, waistbands, bras, pantyhose, or even rings on the fingers, bother you?

18. Are you bothered by noises, like chalk on a chalkboard or people chewing?

19. Are you bothered by light, like fluorescent lighting or car headlights or sunlight?

Initial Questionnaire

20. Are you bothered by odors, like perfume, gasoline, cleaning chemicals, room deodorizers or even flowers or essential oils?
21. Do you have any specific fears? *For example: speaking to a group, taking tests, bugs, spiders, dogs, other animals, standing at a tall place looking down, being alone, being in an elevator, flying, in or on water etc.*
22. What are you drawn to? *For example: machines, people, animals, plants, rocks/minerals, community activities, water, mountains etc.* Do you have any hobbies? Do you have any collections of things?
23. Do you have any problems with sleep?
24. What is your favorite sleep position? Is there a sleep position that is uncomfortable for you?
25. Do you now or in the past, talk, laugh, cry, moan, snore, scream, walk, jerk, or grind or clench your teeth in your sleep?
26. Do you suffer from restless legs in bed or leg cramps?
27. Do you uncover any part of your body during sleep or do you like to be well covered?

Initial Questionnaire

28. Do you remember your dreams? Are there themes to your dreams? Do you have recurring dreams?

29. In general, do you wake up feeling refreshed in the morning?

30. What is your mood upon waking in the morning?

31. When do you get to bed at night? When do you get to sleep? When do you wake up?

Initial Questionnaire

32. What do you eat on an average day for breakfast? Do you eat breakfast?

33. What do you eat on an average day for lunch?

34. What do you eat on an average day for supper?

35. What do you eat for snacks? And when?

36. How thirsty are you? What do you like to drink? Do you use ice in your drinks?

37. What foods do you crave or love? What do you eat for pleasure?

38. What foods do you strongly dislike?

39. What foods cause symptoms when you eat them? What reaction do you have?

Initial Questionnaire

40. Please **rate** the following foods and tastes, **10** being something you love. Here are some food and drink suggestions; feel free to add your favorites.

Tastes & _____

Textures: _____

sweet

sour

salty

spicy

smoked

bitter

crunchy

creamy

slippery

Temperature:

hot food

cold foods

hot drinks

cold drinks

ice

Drinks:

alcohol

coffee

tea

soda

juice

sparkling water

Foods:

meat

fat on meat

fish

chicken

shellfish

pork

bacon

milk

cheese

yogurt

ice cream

butter

eggs

chocolate

bread

pasta

cakes

pastries

nuts

pickles

fruit

lemons

oranges

raw veggies

cooked veggies

salads

onions

olives

garlic

Peculiar things:

sand

dirt

clay

chalk

coffee beans

paste

Initial Questionnaire

41. What medications and/or supplements are you taking and what are they for?
Please list:

a. Medication name:

for what condition:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

b. Supplement name and ingredients:

for what condition:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____