NEW CLIENT/PATIENT QUESTIONNAIRE

Dear Client/Patient,

Our 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 these written questionnaires. The doctor is the only person who will review these forms and your confidentiality will be strictly maintained. Your careful consideration of each of the following questions will enhance the doctor's efficiency and will provide for more effective use of your scheduled consultation time. If you come across questions you don't know the answers to, simply leave these blank and proceed from there. Thank you for your time in advance and we look forward to working together to achieve your health goals.

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New Patient Questionnaire

Name: Date of Birth: (mm) (dd) (yy)
Age: Height: Weight:
Address:
City: State: Zip Code:
Home Phone: ( ) Cell phone: ( )
Bus. Phone: ( ) E-mail:
Occupation: Marital Status: (Single/Married/Divorced)
Number of children: Are you a smoker?: (Y/N) Past smoker? (Y/N)
How did you hear about our clinic?

1. Please state your primary reason for attending our clinic. If this involves a specific health condition, please describe it in detail. List the very first time you noticed the condition and describe carefully any factors that you suspect may have played a role in its onset and perpetuation. Please list every detail and give the Doctor the opportunity to distinguish what may or may not be relevant to your case. (Please use the back of this sheet or attach another sheet if more space is required).

2. How long has it been since you really felt good? What changed in your life prior to the onset of your current complaint (e.g. diet, activity level, toxin exposure, job, injury, illness, medication, travel, relationships, sleep, stress levels, etc.)?

3. Are you happy with your life? If not, please explain.

4. Is your health currently getting better, worse or staying the same?

5. What are the most significant measures that you have taken to date to improve your state of health?

6. Do you exercise? If yes, what do you do, how long, and how often?

7. Please list the 5 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.

8. Rate your feelings of stress. Use a scale from zero to ten, with a score of zero being no stress and ten being unbearable stress.

9. Are you currently working with a professional counselor, psychologist, social worker, or therapist? (Y/N)________
   Have you in the past? (Y/N)________
   Do you have a medical doctor? (Y/N)______
   Medical Doctor's Name:_______________________

10. Have you consulted a medical doctor regarding the aforementioned condition(s)? Please explain his/her diagnosis, therapy and the result.

11. Have you consulted any other health practitioners regarding the aforementioned condition(s)? Briefly describe, listing practitioner's name, specialty, treatment suggested or rendered, and the results.

12. Do you attend any other healthcare professionals on a regular basis? (e.g. Chiropractor, Naturopath, Osteopath, Dentist, Acupuncturist, Optometrist, Massage Therapist, etc.)

13. What time do you usually go to sleep?

    What time do you wake?

    Do you sleep soundly? (Y/N)_______

    Do you feel well rested when you wake? (Y/N)____

14. Rate your average energy levels (please circle the appropriate point):

0 1 2 3 4 5 6 7 8 9 10

Non-Existent ... Could Not Be Better

15. Do you feel your age, younger, or older?

16. If you continue on your current path (lifestyle), where do you see your health in ten years?

17. How often do you have a bowel movement?

18. Please list all your secondary health concerns/conditions that you are aware of whether you feel they are related to your primary reason for attending our clinic or not.

19. Please list all drugs (prescription or otherwise) which you are presently using or have used in the past and why. Indicate which drugs are currently used.

20. Do you supplement your diet with vitamins, minerals, herbs or related substances? (Y/N)_______ Please list the product and brand names, content and potencies of all products used. Indicate who prescribed these for you and how he/she determined your specific needs and dosages.

Family Health History:

21. Please indicate whether there is any history of the following conditions in your family (please circle) and give the details below:
    Heart Disease, Stroke, Cancer, Osteoarthritis, Type 2 Diabetes, Osteoporosis, Alzheimer's Disease, Parkinson's Disease, Celiac disease, Crohn's Disease, Ulcerative Colitis, Thyroid disease, Rheumatoid Arthritis, Multiple Sclerosis, Systemic Lupus Erythematosus, Autoimmune Disorders, Asthma, Allergies, Psoriasis, Eczema, Mental Illness, Alcoholism, Drug Abuse or any other conditions which may be pertinent to your present state of health (please attach sheet if space is required):

22. Are you interested in preventing any particular disease or condition?

23. Are you concerned with your memory?

24. Was your mother in excellent health throughout her pregnancy while carrying you? (Please look into it if possible)

25. What was your birth weight?_____________Was your birth premature (Y/N)____ If so, how early were you?

26. Were you delivered by C-section? (Y/N)_________

27. Were you separated from your mother during the first six months after birth? (Y/N)_____ For approximately how long and why?

28. Were you breast-fed? (Y/N)________

29. Were you fed anything other than breast milk during your first six months of life? (Y/N)_____ If so, which foods?

30. Did you require any medical attention, hospitalization, or medication as an infant (before age 2) (Y/N)_____ As a child (age 2 to 10)? (Y/N)_____ Please explain any "Yes" answers in detail.

31. Did you have a happy childhood (i.e. good relationship with parents)?

32. Have you had any surgery? (Y/N)_____Please list all surgeries, their approximate dates, and if you feel they were successful.

33. Have you ever been diagnosed as having Cancer, Diabetes, Multiple Sclerosis, Arthritis, AIDs, Hepatitis, Chronic Fatigue Syndrome, Cardiovascular disease, Thyroid disease or any other condition? (Y/N)_____ Please explain.

34. Have you ever had any disease condition involving your bones, joints, muscles, ligaments, or tendons? (Y/N)_____ Please explain.

35. Have you had any bad sprains or broken bones due to accidents or sports? (Y/N)________ Please provide the details.

36. Have you ever had X-rays, C.T. scans, or M.R.I.s done? (Y/N)____ When? Were any abnormalities found?

37. Have you had any re-occurring infections or inflammations? i.e. Periodontal disease, Gingivitis, Tonsillitis, Vaginitis, Colitis, Sinusitis, Yeast overgrowth, Bladder or Ear infections, etc.? (Y/N)______ Please explain fully.

38. Do you have root canals, implants, dentures, gingivitis or other conditions of your teeth or gums?

39. Do you have silver (mercury amalgam) fillings in your teeth? (Y/N)______

40. About how many times in your life have you taken antibiotics?

41. What do you feel your weakest organ system is, and why? (i.e. lungs, liver etc.)

42 How many times each year do you have a Cold, Sinusitis, the Flu, Sore throat or bronchitis? How long do they usually last and are they severe?

43. Do you take any medication for the above? (Y/N)______ If so, what kind?

44. Are you aware of having any allergies to foods, drugs or inhalants?
(Y/N) ___ How do you react? Please list and describe in detail.

45. How much detail would you like in regard to personalized health education?
(Please circle or underline one response)

A. Just tell me what I need to do.

B. Give me a summary of what's going on with me.

C. I would like a lot of information.

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."*

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biochemical processes of the human body.

I have read and understand the above:

Signature ______________________________________ Date ____________________

Note: This questionnaire is strictly confidential between you and the Doctor and your accurate responses are vital to effective health care at this office. Please go back over your responses and consider their accuracy. *Thank you!*