

ADULT MEDICAL QUESTIONNAIRE

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 both these written questions and those posed by the clinician 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 health challenges. Your careful consideration of each of the following questions will enhance our 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 us in formulating a treatment plan.

First Name: _____		Middle Name: _____		Last Name: _____	
Address: _____		City: _____		State: _____ ZIP: _____	
Home Phone: (_____) _____ - _____		Birth Date: ____/____/____		Age: _____	
		month day year			
Work Phone: (_____) _____ - _____		Place of Birth: _____			
Occupation: _____		City or town & country if not US			
Referred by: _____		Height: ____' ____"		Weight: _____ Sex: _____	
Today's Date _____					

1. Please check appropriate box(es):

- | | | | |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

2. 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: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

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

Example: Wendy, age 7, sister

4. Do you have any pets or farm animals? Yes___ No___
If yes, where do they live? 1. ___ indoors 2. ___ outdoors 3. ___ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes___ No___
If so, when and where? _____

6. Have you or your family recently experienced any major life changes? Yes___ No___
If yes, please comment: _____

7. Have you experienced any major losses in life? Yes___ No___
If so, please comment: _____

8. How important is religion (or spirituality) for you and your family's life?

- a. ___ not at all important
- b. ___ somewhat important
- c. ___ extremely important

9. 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

10. Previous jobs:

11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

- a. Did you feel safe growing up?
 Yes No
- b. Have you been involved in abusive relationships in your life?
 Yes No
- c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
 Yes No

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- d. Do you currently feel safe in your home?
 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
- g. Would you feel safer discussing any of these issues privately?
 Yes No

12. Past Medical and Surgical History:

ILLNESSES	WHEN	COMMENTS
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		
ILLNESSES	WHEN	COMMENTS
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)		

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INJURIES		WHEN	COMMENTS
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
DIAGNOSTIC STUDIES		WHEN	COMMENTS
ag.	Barium Enema		
ah.	Bone Scan		
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		WHEN	COMMENTS
au.	Appendectomy		
av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

13. Hospitalizations:

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

14. How often have you have taken antibiotics?

< 5 times **> 5 times**

Infancy/ Childhood		
Teen		
Adulthood		

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

< 5 times **> 5 times**

Infancy/ Childhood		
Teen		
Adulthood		

16. 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: _____

17. 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.		

18. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				

c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

19. As a child, were there any foods that you had to avoid because they gave you symptoms?
 Yes____ No____

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)

20. Place 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	
	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
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)	

21. 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	

22. Are you on a special diet? Yes___ No___
 ___ ovo-lacto ___ vegetarian ___ other (describe):
 ___ diabetic ___ vegan _____
 ___ dairy restricted ___ blood type diet _____

23. Is there anything special about your diet that we should know? Yes___ No___
 If yes, please explain: _____

24. a. Do you have symptoms immediately after 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.

25. Do you feel you have delayed 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___

26. Do you feel much **worse** when you eat a lot of :
 ___ high fat foods ___ refined sugar (junk food)
 ___ high protein foods ___ fried foods
 ___ high carbohydrate foods ___ 1 or 2 alcoholic drinks
 (breads, pastas, potatoes) ___ other _____

27. Do you feel much **better** when you eat a lot of :
 ___ high fat foods ___ refined sugar (junk food)
 ___ high protein foods ___ fried foods
 ___ high carbohydrate foods ___ 1 or 2 alcoholic drinks
 (breads, pastas, potatoes) ___ other _____

28. Does skipping a meal greatly affect your symptoms? Yes___ No___

29. Have you ever had a food that you craved or really "binged" on over a period of time?
 Food craving may be an indicator that you may be allergic to that food. Yes___ No___
 If yes, what food(s)? _____

30. Do you have an aversion to certain foods? Yes___ No___

If yes, what foods? _____

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

a. Frequency	√	b. 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		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

32. Intestinal gas: _____ Daily _____ Present with pain
 _____ Occasionally _____ Foul smelling
 _____ Excessive _____ Little odor

33. 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 per week
 _____ Average 4-6 drinks per week
 _____ Average 7-10 drinks per week
 _____ Average >10 drinks per week

c. Have you ever had a problem with alcohol? Yes____ No____
 If yes, please indicate time period (month/year): from _____ to _____.

34. Have you ever used recreational drugs? Yes____ No____

35. Have you ever used tobacco? Yes____ No____

If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
 If yes, what type of nicotine have you used? _____Cigarette _____Smokeless
 _____Cigar _____Pipe _____Patch/Gum

36. Are you exposed to second hand smoke regularly? Yes____ No____

37. Do you have mercury amalgam fillings? Yes____ No____

38. Do you have any artificial joints or implants? Yes____ No____

39. Do you feel worse at certain times of the year? Yes____ No____

If yes, when? _____spring _____fall
 _____summer _____winter

40. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
 If yes, which one(s)? _____lead _____cadmium
 _____arsenic _____mercury
 _____aluminum

41. Do odors affect you? Yes____ No____

42. 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					

43. Have you ever had psychotherapy or counseling? Yes____ No____
 Currently? _____ Previously? _____ If previously, from _____ to _____.
 What kind? _____
 Comments: _____

44. Are you currently, or have you ever been, married? Yes____ No____
 If so, when were you married? _____ Spouse's occupation _____
 When were you separated? _____ Never _____
 When were you divorced? _____ Never _____
 When were you remarried? _____ Never _____ Spouse's occupation _____
 Comments: _____

45. Hobbies and leisure activities: _____

46. Do you exercise regularly? Yes____ No____
 If so, how many times a week? When you exercise, how long is each session?
 1. _____ 1x 1. _____ ≤15 min
 2. _____ 2x 2. _____ 16-30 min
 3. _____ 3x 3. _____ 31-45 min
 4. _____ 4x or more 4. _____ > 45 min

 What type of exercise is it?
 _____ jogging/walking _____ tennis
 _____ basketball _____ water sports
 _____ home aerobics _____ other _____