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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 these 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 to formulate a treatment plan.

Today's Date: ____________________________

First Name: ________________ Middle Name: _______________ Last Name: ________________________

Address: ______________________________ City: ___________________ State: _______ ZIP: _________

Cell Phone: (________) ________-___________   Birth Date: _____/____/____ (month day year)   Age: _________

E-mail: __________________________________

Place of Birth: _____________________________
City or town & country if not US

Occupation: ________________________________

Referred by or how did you find us: ______________________________

Height: ___′ ____ ″ Weight: _______ Sex: _____

Primary Care Physician: __________________________

Please list other physicians or specialists you are currently seeing or have seen in the past, including chiropractic and naturopathic physicians.

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

1. Please check appropriate box(es):

African American	Hispanic	Mediterranean	Asian
Native American	Caucasian	Northern European	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. What medications are you taking now? Include non-prescription drugs.

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

4. Are you **allergic to any medications**? Yes____ No____
   If yes, please list: ____
   ____

5. 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 in mg	Quantity and frequency Example: 2 caps twice daily
1.			
2.			
3.			

4.			
5.			
6.			
7.			
8.			
9.			
10.			

6. 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 (A, B, or C)		
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		

		WHEN	COMMENTS
z.	Thyroid disease		
aa.	Other (describe)		
	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)		
	Surgeries	**WHEN**	**COMMENTS**
au.	Appendectomy		
av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia (inguinal, umbilical, or other---)		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

7. Hospitalizations:

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

8. NUTRITION-

Are you on a special diet? Yes____ No____

_____ gluten free _____ vegetarian _____ Low carb/Keto

_____ diabetic _____ vegan _____ dairy restricted

_____ blood type diet _____ other (describe): _________________________

9. 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)	

10. 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	

11. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain:
____

12. 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.
____
____

13. 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____

14. 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 ______________________________

15. 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 ______________________________

16. Does skipping a meal greatly affect your symptoms? Yes____ No____

17. 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)? ____

____

18. Do you have an aversion to certain foods? Yes____ No____
    If yes, what foods? ____

19. 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			

20. Intestinal gas: _______Daily _____ Present with pain
    _______Occasionally _____ Foul smelling
    _______Excessive _____ Little odor

21. 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 ___________.

22. Have you ever used recreational drugs? Yes____ No____

23. 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

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

25. Do you have mercury amalgam fillings? Yes____ No____

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

27. Do you feel worse at certain times of the year? Yes____ No____
    If yes, when? _______spring _______fall
    _______summer _______winter

28. 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

29. Do odors affect you? Yes____ No____

30. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
    Example: Wendy, age 7, sister
    ____
    ____
    ____

31. 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

32. Have you lived or traveled outside of the United States? Yes____ No____
    If so, when and where? ____
    ____

33. Have you or your family recently experienced any major life changes? Yes____ No____
    If yes, please comment: ____
    ____

34. Have you experienced any major losses in life? Yes____ No____
    If so, please comment: ____
    ____

35. How important is religion (or spirituality) for you and your family's life?
    a. _____ not at all important
    b. _____ somewhat important
    c. _____ extremely important

36. 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

37. Previous jobs:
    ____
    ____
    ____

38. 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
    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

39. How often have you have taken antibiotics?

	< 5 times	**> 5 times**
Infancy/ Childhood		

Teen		
Adulthood		

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

	< 5 times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

41. 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?				

42. 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)

____

____

____

43. 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					

44. Have you ever had psychotherapy or counseling? Yes____ No____

Currently? _____ Previously? _____If previously, from ______ to _______.

What kind? ____

Comments: ____

45. 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: ____

46. Hobbies and leisure activities: ____

____

47. Do you exercise regularly? Yes____ No____

If so, how many times a week?

1.______1x

2.______2x

3.______3x

4.______4x or more

When you exercise, how long is each session?

1.______ ≤15 min

2.______ 16-30 min

3.______ 31-45 min

4.______ > 45 min

What type of exercise is it?

_______jogging/walking

_______basketball

_______home aerobics

_______tennis

_______water sports

_______other _______________________________________

48. **Anything else that is important to you that was not covered?**