**Questionnaire**

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| --- | --- |
| Date: | Date of Birth:  |
| Name: | Ht: |
| Address: | Wt: |
| City, St, Zip: | Email: |
| Phone: | Skype address: |

**CHIEF COMPLAINT**

What is your chief complaint [*please explain fully*]

What do you think caused it?

When did this problem begin?

What makes your chief complaint feel worse? [*certain types of foods, weather, movement, light, noise, heat/ cold, or anything else that you can think of, please be specific*]

What makes your chief complaint feel better? [*rest, heat, open air, eating or anything else you can think of, please be specific*]

At what time of the day or night is your chief complaint worse? [*specify an hour if you can*]

What symptoms, if any, can you identify that accompany the chief complaint?

**PHYSICAL**

What major illnesses have you had? [*please include childhood diseases and approximate age*]

Have you had any childhood diseases more than once, after puberty, or two at the same time?

Do you have lax ligaments, low muscle tone, “double-jointed” elbows, wrists, or knees?

Do you now have, or have you ever had, any of the following conditions?

Eye inflammation (Conjunctivitis, Pink Eye, discharge of any kind, etc)

Tonsillitis (strep throat)

Staph Infection

Mononucleosis (*aka* *Êpstein-Barr ,Glandular Fever, Kissing Disease*)

Sexually Transmitted Diseases (*i.e.* *PID, Herpes, HPV, Chlamydia, etc*.)

Mumps

Asthma / Croup / Bronchitis / Pneumonia

Organ disease [*heart, liver, pancreas, kidney, uterine, prostate, lungs, etc*]

Arthritis (Osteo, Rheumatoid)

Gout

Ulcers

Haemorrhoids

Varicose Veins

Urinary Tract Infections

Kidney or Gall bladder stones

Skin conditions such as eczema, psoriasis, etc.

Yeast (Thrush, Candida)

Diabetes/Hypoglycemia

Elevated blood pressure

Elevated cholesterol

Cancer

What medical problems have you been treated for?

What surgeries have you had and when?

If you have had any skin problems, such as acne, eczema, ringworm, psoriasis, how was it treated?

Have you been vaccinated after childhood, including flu shots? When and what for?

Have you ever had a bad reaction to a vaccine? What were your symptoms?

Do you have any amalgam dental fillings or root canals? How many?

Do you run on the warm or cold side? Are any body parts colder or hotter than others?

At what time of day is your energy at its highest and lowest?

How frequently do you get colds and flus?

What kind of exercise do you do? Do you feel better or worse from exercise?

Do you have any urinary problems?

Do you have any digestive problems?

How frequent are your bowel movements? Are they normal, loose, or difficult?

Do you have any implants or surgical pins?

**WOMEN’S HEALTH**

Have you ever had an abnormal PAP smear, and if so what was the diagnosis?

Have you ever used a birth control method? If yes, which product(s) and for how long?

Number of pregnancies, number of children, number of miscarriages.

If you have taken fertility drugs such as Clomid, Depo-prevera, etc, please list them, when you took them, and how many times you took them.

Have you ever received estrogen or progesterone therapy?

Did you take any drugs during pregnancy?

At what age did your menses begin and end?

**MENSTRUAL CYCLE (*if you are post-menopausal skip this section)***

How frequently are your periods?

Please tell me about duration, abundance, color, time of day when flow is greatest, odor, or clots.

Do you now have, or have you ever had an abnormal vaginal discharge (i.e. green, thick, lumpy, foul odor, etc) Please describe.

How do you feel before, during, and after menses?

If you are peri-menopausal what are your symptoms?

**MEDICATIONS / SUPPLEMENTS / REMEDIES**

What medications have you taken? Please list the names and what they were for.

What herbs, vitamins, or other supplements are you taking?

Have you been treated homeopathically before? If so, please list the remedies you’ve taken.

**SENSITIVITY**

Do you tend to need smaller doses of medications than most other people?

Do you react to vitamins and herbs?

Do you have sensitivity to paint fumes, exhaust fumes, dry cleaning fluid, fragrances, etc?

**SLEEP**

Do you have any problems getting to sleep, staying asleep, or sleeping enough hours?

Do you have recurring or vivid dreams?

**FOOD AND DRINK**

Do you have any food allergies or sensitivities?

How thirsty are you? What types of beverages do you drink? Do you have a preference for hot or cold drinks?

Do you have strong desires or aversions to certain foods or drinks?

**MENTAL EMOTIONAL**

Are you a moody person?

Do you tend to get angry or impatient?

Do you have any addictions, such as coffee drinking, nail biting, pornography, etc?

Are you a hurried or slow person?

How is your ability to focus and concentrate?

Do you have any fears or phobias?

What do you (or did you) do for work? What would you like to do?

What would you most like to change about yourself?

How would your partner, children, parents, or others, want you to be different?

**FAMILY HISTORY**

List current conditions and diseases of family members within at least one generation, and causes of death for parents, siblings, and/or grandparents.

**ADDITONAL COMMENTS**