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New Patient Questionnaire

Your answers in the following health questionnaire are confidential and will be used to help develop an individualized treatment plan to best suit your healthcare needs.

1) Please list any symptoms you would like to address via your treatments (we will discuss them in more detail during your initial visit):

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•	•
•	•
•	•
•	•
•	•
•	•
•	•
•	•

Are any of these symptoms hindering your ability to function in your daily life?

2) Please list any Western medical diagnoses you have received (or diagnoses you suspect) that are still relevant to your present health situation.

•	•
•	•
•	•

3) Please list any significant diseases or syndromes, chronic or recurrent infections, and chronic pains (past and/or present).

Disease or syndrome/ infection/ chronic pain (include approximate dates):	Treatment received for the condition:	Current symptoms:

4) Please list any allergies (food, environmental, medications, herbs, etc.):

•	•	•	•
•	•	•	•
•	•	•	•

5) What are your treatment goals?

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6) Please list any significant life transitions or growth processes you are experiencing (if you feel they might relate to your treatments):

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•
•

7) Family medical history:

Are your parents still living? Mother - Y N Father - Y N
What are the significant health conditions affecting your parents and grand-parents? If they have passed, how did they die?
Mother: _____
Father: _____
Maternal Grandmother: _____
Maternal Grandfather: _____
Paternal Grandmother: _____
Paternal Grandfather: _____
Other relevant family medical history information:

8) Personal history:

Birth:
Where were you born?
Did your mother have a natural delivery or c-section (please circle to indicate)?
vaginal birth epidural c-section
Was it a home birth (please circle)? Yes/No
Where there any complications with your birth, such as the umbilical cord being wrapped around your throat?

Do you know more details about your birth? If so, please describe briefly:

Please list the places you lived before the age of 18, including # of years lived in each place:

Do you have any siblings? If so, how many and where are you in the birth order?

Please list any childhood experiences of significant emotional upset (divorce of parents, loss of a loved one), trauma, and/or abuse:

9) General health information:

Headaches/migraines:
Do you get headaches or migraines? Yes/No
Location(s) of headaches: _____
Frequency: _____ How long have you been getting them? _____
Time of day: _____ Pain scale (1-10): ___
Quality of pain (dull, achy, sharp, throbbing, heavy, constant, etc.): _____
Does anything help with the pain? _____
Does anything make the pain worse? _____
Does anything seem to trigger the headaches to start? _____

Energy:
How is your energy level in general (circle one)? low average above average
Time of day energy is lowest: _____ Level (1-10): _____
Time of day energy is highest: _____ Level (1-10): _____
Do you feel like you could sleep all day long? Yes/No
Do you fatigue easily? Yes/No Do you find that you need to nap during the day? Yes/No
Do you feel tired after you eat? Yes/No

Sleep:
Average hours of sleep per night? _____
Do you have difficulty falling asleep? Yes/No
Do you wake up during the night? Yes/No
If yes, are you able to go back to sleep? Yes/No How many times do you wake up during the night? ___
Do you wake up early and find you can't go back to sleep? Yes/No If so, what time? _____
Do you feel rested when you wake up? Yes/No
Do you ever have night sweats? Yes/No If so, how often? _____

Sweat:
Please circle all that apply:
profuse sweating inability to sweat spontaneous sweating night sweats
Quality of sweat (cold, sticky/watery)? _____
Do you tend to sweat mostly from a particular area of your body? _____
Do you tend to sweat at a particular time of day? If so, what time? _____

Digestion and bowel movements (BM):
BM frequency: ____ BM in the morning? Yes/No Size of stool (small, pebbles, etc): _____
Do you tend towards diarrhea, loose stools, or constipation (or alternate between)? _____
BM consistency (dry, sticky, loose, compacted, thin, floating): _____
Do you ever have a need to wipe excessively? Yes/No
Unusual color in stool (black, bloody, mucus, light colored): _____
Do you ever notice food in your stool? Yes/No
Do your BMs feel complete? Yes/No Is there any discomfort after a BM? Yes/No
Do you ever have pain that is relieved by your BM? Yes/No

Do you ever have any of the following digestion symptoms (circle all that apply)?
gas bloating indigestion belching hiccups nausea vomiting acid reflux
poor appetite excessive appetite always hungry abdominal pain gall stones
tired/sluggish after eating vomit after eating distention/indigestion after eating

Do you crave any particular foods? _____
Do you ever notice a taste in your mouth? Yes/No If so, please describe it: _____

Urination:
Typical color: _____ Frequency: _____
Pain with urination: Yes/No If yes, is the pain before, during, or after? _____
Please circle all that apply:
interrupted stream incontinence/dribbling copious urination rough flow
retention of urine decreased flow waking in the night to urinate kidney stones

Thirst:
Please circle all that apply:
excessive thirst no thirst thirst with no desire to drink thirst with desire to sip drinks
desire for hot drinks desire for cold drinks

Mood:

Do you tend toward any particular emotions? _____

Do you tend toward any particular emotions when you are stressed out? _____

For women, do you tend towards any particular emotions before, during, or after menstruation?

_____

Please circle all that apply:

depression anxiety panic attacks cries easily inappropriate laughter PTSD
grief irritability anger sadness worry over thinking fear overwhelm
emotional distress addiction

How is your stress level? _____ How do you manage the stress in your life? _____

_____

Are you satisfied with your job/career and/or chosen life focus (such as staying home to raise kids or devoting your life to living alternatively)? Yes/no

Please list any significant emotional experiences and/or traumas you have experienced (significant loss, death of a loved one, divorce or loss of relationship, etc.):

Men's health:

Sexual function (please circle all that apply):

impotence premature ejaculation inability to maintain erection night time emission
wet dreams pain with ejaculation anxiety related to sex and/or intimacy

Women's health:

Menstruation:

(*If you are in menopause, please answer the questions according to your history.*)

How old were you when you had your first menses? ___

Do you have a regular menses? Yes/No

If yes: cycle length____ # days bleeding____

If no: please describe the variance of your cycle length and number of days of bleeding.

_____

_____

Flow quantity:

Color – Beginning _____ Middle _____ End _____ clots: Yes/No

Spotting: Yes/No If yes, when do you see the spotting? _____ What color is it? _____

Cramping: severity (1-10) ___ When does the cramping start and stop? _____

Where do you feel the cramping? _____

Birth control: Yes/No If yes, what type and how long have you taken it?

Have you ever had an abnormal pap smear or gynecological exam? Yes/No

If yes, when was the exam and what were the findings? _____

_____

Other information:

Pregnancy:
Are you currently pregnant? Yes/No Are you currently trying to get pregnant? Yes/No
Number of pregnancies? ____ Number of births? ___
Have you ever had a miscarriage? Yes/No If yes, how many times? _____
Have you ever had an abortion? Yes/No
Have you ever had treatment for infertility? Yes/No If yes, what type of treatment? _____
_____

Menopause (if applicable):
Age of last menstruation: ____
Please describe any symptoms you are experiencing:

Are you taking HRT? Yes/No

10) Is there anything else you would like for me to know about you and/or your healthcare needs?

11) Please list any supplements, herbs, and medications you are currently taking:

medications, herbs, and/or supplements:	Please specify the reason for taking the medicinal substance (include if it was prescribed and who it was prescribed by):	Approximately how long have you been taking this medicinal substance?

12) Please list any history of significant injuries, serious illnesses, and hospitalizations:

Injuries/hospitalizations/ serious illness (include approximate dates):	Treatment received for the condition:	Current symptoms: