For Office Use Only
Date Sent ___/___/___
Date Rec'd ___/___/___
IC Tech Score_____

Confidential Client Questionnaire

General Information – Please Print

Date ____/____/____

Patient Name _____ Home Address _____

City _____ State _____ Zip _____ How long? _____

E-mail _____@_____ *We do not share your address.*

The doctor may communicate with you via e-mail.

Birth date ____/____/____ Age ____ Sex M F Marital status: Married/Single/Divorced/Widowed

Telephone: Home _____ Work _____ Cell _____

Previous address if less than 3 years at present

Address _____ City _____ State _____ Zip _____

Your Employer _____ City _____ Years with firm _____

Occupation _____ SSN _____/_____/_____

Spouse's name _____ Birth date ____/____/____ Occupation _____

Spouse's Employer _____ City _____ Phone _____

Your MD _____ Clinic _____ Last physical _____

Dentist _____ Clinic _____ Last visit _____

Chiropractor _____ Clinic _____ Last Adjustment _____

In case of emergency, contact _____ Phone _____

Who may we thank for referring you to us? _____ Phone _____

Please fill out the following as completely as you can. Use additional blank sheets if necessary. Obtaining the best health possible is a process that can only occur with your participation. The information you provide will help your doctor make informed recommendations. Thank you.

Your Health History

Give the primary reason you are consulting with our doctor. Be sure to give a detailed account, including when and why it started, what has been done to date, the results you have had, and if the problem is getting better, worse, or is the same.

Give any secondary health problems you are experiencing. List the most severe first.

List all nutritional supplement products you are taking. Include the name of the company, amount, why you are taking them, and how long you have been taking them. We ask that you bring all bottles to your consultation.

Name	Company	Amount	Why taking?	How Long?

List all drugs (prescription or not) you are taking. Include the reason taking, amount, length of time taken, and results. List all other drugs you have taken in the past.

Name	Amount	Why taking?	How Long?	Results

List all surgeries you have had, including the date, why it was done, and the results.

Surgery	Date	Why done?	Results

List all allergies you have to food, drugs, or other substances, along with the symptoms they produce and indicate how long you have suffered from each item.

Allergy	Symptoms	How Long?

Answer the following questions to the best of your ability. If you don't know the answer, leave blank.

( ) yes ( ) no My mother was healthy while pregnant with me. If no, describe _____

( ) yes ( ) no Was your birth natural? If no, please check ( ) anesthesia ( ) forceps ( ) c-section

( ) yes ( ) no Were you breast fed for at least the first six (6) months?

( ) yes ( ) no Were you fed anything other than breast or cow formula milk in the first six (6) months? List items _____

( ) yes ( ) no Were you a colicky baby? Until what age? _____

( ) yes ( ) no Have you ever been to or lived in a foreign country? List _____

( ) yes ( ) no Have you ever fainted or had a convulsion? Describe _____

Mark any you have had:

( ) Measles	( ) Chicken pox	( ) Hepatitis	( ) Shingles
( ) Scarlet Fever	( ) Lymes Disease	( ) Rheumatic Fever	( ) Herpes
( ) HIV/Aids	( ) German Measles	( ) Mumps	
( ) Mononucleosis		( ) Venereal Disease _____	

Diet History – Mark each one using a "0" or none when appropriate

Give the amount of each you consume

_____oz water	____day	____not daily
_____oz alcohol	____day	____not daily
_____oz coffee/tea	____day	____not daily
_____oz soda	____day	____not daily
_____oz juice	____day	____not daily
_____other _____		

List your 10 most favorite foods eaten most frequently: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Give percentage for each of the following. Total for each line to equal 100%.

Where daily diet prepared: ____home ____restaurant ____fast food ____vending machine

How food prepared: ____baked ____broiled ____boiled ____fried ____steamed ____micro ____grilled

Food prepared from: ____fresh ____canned ____frozen ____prepackaged

My appetite is: ( ) normal ( ) excessive ( ) poor ( ) none

I crave: ( ) sweets ( ) salt ( ) chocolate ( ) water ( ) dirt ( ) other _____

Type of water used for drinking/cooking: ( ) tap or city ( ) spring ( ) well ( ) rain
( ) bottled distilled ( ) bottled filtered ( ) reverse osmosis

If purchase water, is it in: ( ) soft plastic ( ) hard plastic ( ) glass

Foods that disagree with you: ( ) raw vegetables ( ) raw fruit ( ) fats ( ) fried ( ) beans
( ) sugar ( ) milk/dairy ( ) greasy ( ) eggs ( ) onions ( ) cabbage ( ) highly spiced
( ) other _____

What symptoms do you get from foods that disagree with you? _____

_____

_____

Do you fast? ( ) yes ( ) no **If yes, how often and how long?** _____

Have you ever done a detoxification program? ( ) yes ( ) no **Explain** _____

_____

Check any of the following diets you have ever tried:

( ) low cholesterol ( ) low salt ( ) low purine ( ) all energy ( ) low fat ( ) diabetic
( ) renal/kidney ( ) high fiber ( ) ulcer ( ) diverticulitis ( ) complex carbohydrate
( ) high protein ( ) weight loss (list which ones) _____

What is your current weight? _____ **Most ever weighed?**_____ **At what weight do you feel best?** _____
Have you gained or lost more than 5 pounds in the past 6 months? YES NO
Exercise - How many days per week? _____ **Minutes per day?** _____ **Type?** _____

Bowel Health

BM = Bowl movement or stool

How many times do you have a BM? _____**times/day** _____**times/week**

Do you use laxatives? ( ) yes ( ) no **How often?** _____

Do you get the urge to have a BM? ( ) yes ( ) no **Do you have pain with BM? ( ) yes ( ) no**

Answer key for the following: 0 = never 1 = rarely 2 = frequently 3 = always

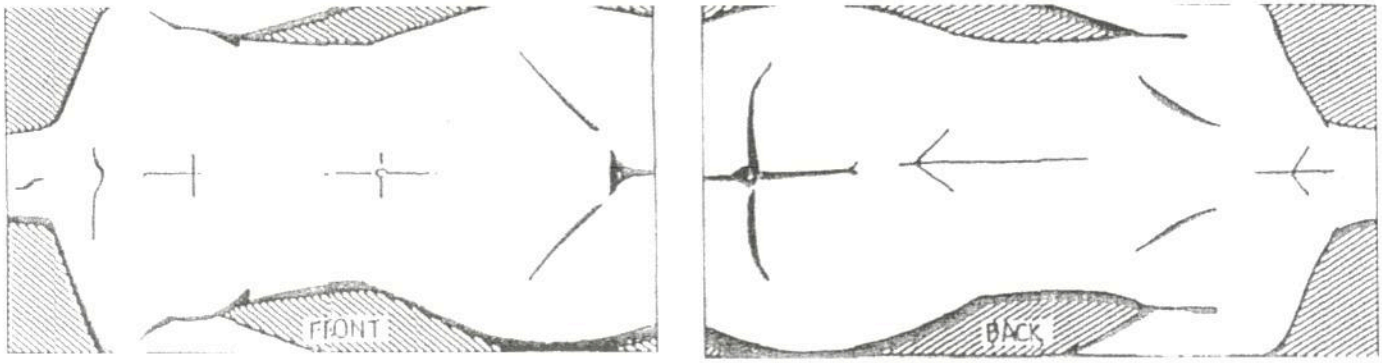
Stool size	Stool consistency	Stool color
____2"wide & 6+" length	____float like a submarine	____med/dark brown
____1"wide & 4+" length	____float on top of water	____very dark/black
____thin, long or narrow	____sink to bottom	____yellow/tan/clay
____small, hard	____loose but not watery	____greenish
____large, hard	____diarrhea	____blood is visible
____difficult to pass	____alternate hard/diarrhea	____mucous in/around

( ) yes ( ) no **Have you ever had worms or parasites?** **How treated?** _____

( ) yes ( ) no **Do you presently have rectal itching?** **( ) day** **( ) night** **( ) continuously**

Digestion

Mark any areas of distress associated with food intake on the diagrams.



I get pain/heartburn: **( ) before eating** **( ) after eating** **( ) when lie down** **( ) upon arising**

I have: **( ) indigestion** **( ) belching** **( ) GERD** **( ) intestinal gas** **( ) bloating**

( ) immediately after eating **( ) 1-2 hours** **( ) 3-5 hours** **( ) 6+ hours**

( ) no odor **( ) some odor** **( ) odor usually** **( ) fowl smelling**

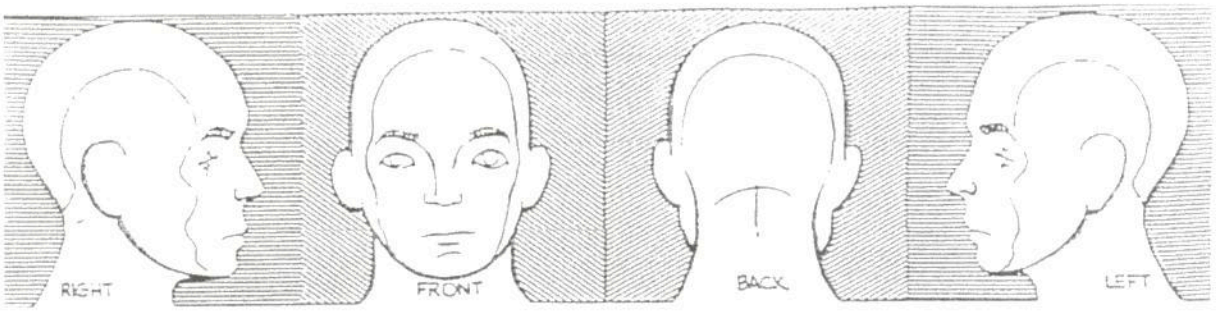
( ) hiatal hernia **( ) esophageal burning/reflux** **( ) raise head of bed to sleep**

List any drugs (prescription or not) or natural remedies you take for any stomach or bowel symptoms.

Product	Dose	How frequently?	Results

Head Mouth Throat

Mark any areas of headache or pain. Mark all that apply.



My teeth are: ( ) good ( ) some fillings ( ) bad ( ) some missing ( ) all missing ( ) root canal

I wear dentures: ( ) upper ( ) lower ( ) partial ( ) crowns ( ) more than 1 metal type in mouth

My breath is: ( ) good ( ) slight odor ( ) odor off/on ( ) offensive odor usually

My tongue is: ( ) covered with small taste buds ( ) sore ( ) furrowed ( ) coated _____ color

My tongue color is: ( ) pink ( ) red ( ) red blotchy ( ) pink with red tip

My tonsils are: ( ) normal ( ) removed at age ____ ( ) enlarged ( ) spotted

My sense of taste is: ( ) normal ( ) poor ( ) no taste ( ) over-salt food ( ) canker sores

My lips are: ( ) normal ( ) dry ( ) peel a lot ( ) fever blisters often ( ) cracked in corners

I get headaches: ( ) daily ( ) weekly ( ) rarely ( ) never
( ) wake up with ( ) get in am ( ) get in pm
( ) of different types ( ) with some foods or drinks
( ) with aura ( ) with nausea/vomiting

Muscle Ligament Joint Nerve

I have pain in: ( ) neck ( ) mid-back ( ) low back ( ) hip ( ) knee
( ) ankle ( ) feet ( ) shoulder ( ) elbow ( ) wrist
( ) hands ( ) other _____

I get: ( ) swollen joints ( ) sore joints ( ) joints pop or crack ( ) jaw pops
( ) leg cramps at rest ( ) leg cramps with activity ( ) worse at night
( ) foot cramps at rest ( ) foot cramps with activity ( ) flat feet ( ) burning feet
( ) tingling in hands or feet ( ) restless let syndrome

I have: ( ) nervous tic or twitching – where _____ ( ) Bell's palsy
( ) ringing in ears ( ) Parkinson's ( ) Sciatic neuritis ( ) Multiple Sclerosis
( ) had spinal surgery – where _____ Results _____

Hair Nails Skin

Hair: ( ) course ( ) fine ( ) falls out excessively ( ) turned grey at age ____ ( ) oily ( ) dry

Male beard: ( ) heavy ( ) light or sparse ( ) none **Ethnic background** _____

Female: ( ) facial hair always ( ) facial hair started at age ____ ( ) hair on abdomen or breasts

Fingernails: ( ) normal ( ) brittle/break easily ( ) soft ( ) ridged vertically ( ) white spots
( ) grow fast ( ) ridged horizontally ( ) grow slow ( ) shaped oddly ( ) hangnails

Skin: ( ) normal ( ) oily ( ) dry ( ) flaky ( ) acne ( ) psoriasis ( ) boils
( ) small bumps on upper arms ( ) skin cancer removed on _____
( ) antibiotics for acne at age ____ How long taken? _____

Spots on skin: ( ) warts ( ) moles ( ) small red ( ) large red ( ) brown ( ) white

Hands and feet: ( ) dry cracked or bleeding areas on ( ) hands ( ) heels ( ) feet
( ) ingrown toenails ( ) fungus on feet or nails ( ) athlete's foot

Chest and Heart

Mark any areas of pain or discomfort on diagram

I have chest pain that is: ( ) sharp ( ) dull ( ) severe
( ) radiates to my arm, neck or back
( ) worse at rest ( ) worse on exertion
( ) better w/exercise ( ) no changes w/exercise

My pulse/heartbeat is: ( ) too fast ( ) too slow ( ) skips beats

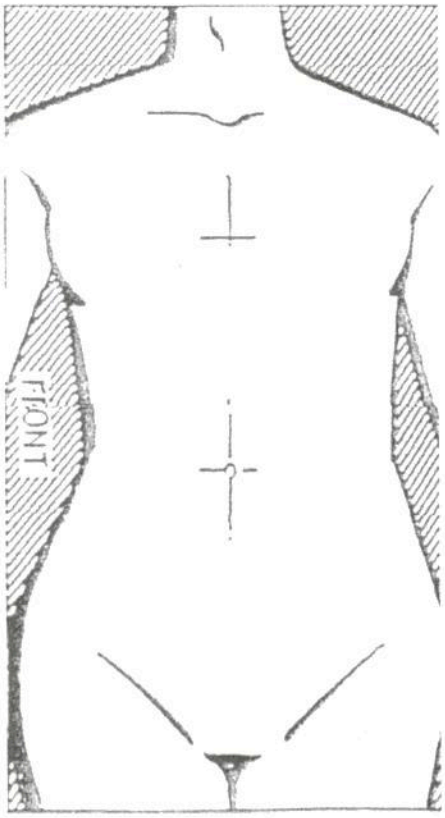
I have: ( ) high blood pressure ( ) low blood pressure

I am: ( ) on HBP medicine ( ) on diuretics

I have had: ( ) a heart attack ( ) bypass surgery
( ) angioplasty ( ) a stroke

I have been told I have: ( ) heart disease ( ) lung disease
( ) clogged arteries

I have: ( ) varicose veins ( ) spider veins
( ) hemorrhoids ( ) had vessel surgery



Respiratory Lungs Allergy Mark all that apply.

I have nasal congestion: ( ) daily ( ) several times per week ( ) only on occasion

I have nasal discharge: ( ) daily ( ) several times per week ( ) only on occasion

( ) clear ( ) yellow ( ) green ( ) blood tinged ( ) other _____

I have: ( ) non-productive cough (w/o mucous) ( ) productive cough (w/mucous)

( ) allergies to _____ ( ) hoarseness of voice ( ) post-nasal drip

( ) hay fever ( ) asthma ( ) wheezing ( ) snoring

I have/have had: ( ) frequent colds ( ) flu once or more times per year

( ) pneumonia ( ) sinus infections

( ) antibiotics three (3) or more times in my life ( ) allergic to _____

I take: ( ) allergy shots ( ) allergy medicine ( ) decongestants ( ) nasal sprays ( ) steroids

I use: ( ) cigarettes ____ pack/day ( ) snuff/chew ( ) cigars ( ) exposed to 2nd hand smoke

I have been told I have: ( ) lung disease _____ ( ) emphysema ( ) COPD

Emotional Nervous Metabolism Mark all that apply.

I am/have: ( ) nervous ( ) anxious ( ) depressed ( ) sensitive to noise ( ) fatigue easily

( ) confused easily ( ) sleepy during day ( ) exhausted a lot

( ) loss of appetite ( ) rage ( ) hear voices ( ) fearful

( ) weakness ( ) poor memory ( ) irritability ( ) morbid thoughts

I am/have: ( ) suspicions of others ( ) thoughts of suicide ( ) quick mood changes

( ) fear of insanity ( ) fear of serious disease like _____

( ) avoid crowds ( ) friends avoid me ( ) have hypoglycemia or low blood sugar

( ) had glucose tolerance test and it was ( ) positive ( ) negative

I: ( ) take daytime naps ( ) dream too much ( ) have no dreams at all ( ) have nightmares

I: ( ) wake up tired ( ) am cold when others are comfortable ( ) feel too hot

( ) have cold hands ( ) have cold feet ( ) perspire too much

( ) have inadequate perspiration when exercise

Do you feel well-rested when you wake up in the morning? ( ) yes ( ) no

____ Rate the quality of your sleep (1 being awful and 10 being great)

Female Specific (Males, please go to next page) Mark all that apply.

Age of first period _____ My menstrual periods are:

( ) normal ( ) painful first day ( ) painful before and during

( ) flow is excessive ( ) have clots or hemorrhage ( ) flow is scanty

( ) regular every ____ days ( ) irregular

( ) no period in ____months ( ) two or more per month

( ) abnormal since ____ years of age

( ) menstrual problems before first child ( ) menstrual problems after first child

( ) weight gain after first child ( ) weight gain after 2nd or 3rd child

Menstrual blood color is: ( ) pink ( ) red ( ) brown ( ) black ( ) other

I have/have had: ( ) endometriosis ( ) constipation w/periods ( ) diarrhea w/periods

Organ drop: ( ) uterus in position ( ) uterus out of position ( ) bladder prolapsed

I am/have been ( ) on birth control (type) _____ ( ) total years on BCP _____

( ) menopause at age _____ ( ) hysterectomy at age _____

I am on hormone replacement: ( ) estrogen ( ) progestin ( ) oral ( ) patch ()implant

( ) wild yam cream ( ) bio-identical formulation

I have breast soreness: ( ) before period ( ) during period ( ) after period ( ) all month long

I have: ( ) fibrocystic breasts ( ) had breast cancer ( ) produce milk but not pregnant or nursing

My breasts are: ( ) firm ( ) soft and saggy ( ) have implants ( ) had reduction surgery

I: ( ) have ____ children ( ) been pregnant ____ times ( ) like children ( ) dislike children

( ) want more ( ) don't want more ( ) am sterile ( ) have fear of pregnancy

I get: ( ) bladder infections ( ) yeast infections ( ) yeast infections after antibiotics

( ) vaginal burning/itching on ( ) inside ( ) outside

( ) vaginal dryness ( ) painful intercourse

I urinate: ( ) ____ times per day ( ) ____ times per night ( ) more frequently than normal

( ) with pain ( ) with difficulty starting/stopping ( ) with itching or burning

My urine color is: ( ) pale yellow ( ) bright yellow ( ) dark yellow ( ) other _____

( ) clear ( ) cloudy ( ) w/mucous ( ) varies a lot

My urine has: ( ) odor describe _____

I have/had: ( ) venereal disease ( ) genital herpes ( ) herpes I ( ) HIV/Aids

My libido is: ( ) normal ( ) excessive ( ) increased ( ) diminished ( ) absent

Libido means desire for sexual relations

Continue at diagram on next page

Are you currently seeing any other health care professional such as dentist, massage therapist, acupuncturist, psychologist, etc? Please explain:

Please fill out your family health history on the chart below.
Put an "N" in the box if have it now, or a "P" if had in the past.

	Alcoholism	Allergies	Alzheimer's Disease	Arthritis	Asthma	Atherosclerosis	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	High Blood Pressure	Kidney Disease	Obesity	Osteoporosis	Sinus Problems	Stroke	Thyroid Problems	Tuberculosis	Ulcers
You																				
Spouse																				
Children																				
Mother																				
Father																				
Maternal Grandparents																				
Paternal Grandparents																				
Sisters																				
Brothers																				

Use this space to add anything else you would like to share about your health concerns or that you think the doctor should know:

Please review this form to be sure your answers are accurate and sign below. Thank you for choosing our clinic. We look forward to working with you on your health goals.

Signature _____ **Date** _____