New Adult Health Questionnaire (Age 18 years or older)

First Name: _____ Middle: _____ Last: _____

Preferred Name (and Title): _____ ☐ Female ☐ Male

Date of Birth: _____ Place of Birth: _____

Genetic History:

☐ African ☐ Asian ☐ European

☐ Mediterranean ☐ Middle Eastern ☐ Native American

☐ Other: _____

Current Job:_____

Nature of Job: _____

Primary Address (Street/Apartment No.): _____

City: _____ State: _____ Zip: _____

Best Phone to Reach You: _____ Alternate Phone: _____

Preferred email address to discuss your health: _____

How did you hear about our services?

_____

Who should we contact if there is an emergency?

Name: _____ Relationship: _____

Phone number: _____

Preferred Pharmacy: _____ Phone Number: _____

City: _____

Compounding Pharmacy: _____ Phone Number: _____

City: _____

What Allergies or Intolerances do you have to medications, airborne, foods, chemicals?

_____

_____

What medicines do you take currently? **(Please list: name, dosage, route and routine)**

_____

_____

What vitamins, herbs, and supplements do you take? **(Please list: name, dosage, route and routine)**

_____

_____

What treatments have you tried in the past? _____

When did you first not feel well? _____

Was anything associated with the onset of your health problem? _____

_____

What are your top 5 health concerns (symptoms) now?

_____

_____

Since the start of your ill health has anything happened to make matters significantly worse?

If previously treated for Lyme provide detailed treatment **(Rx name, route and administration, dose, durations)**

If previously tested for Lyme, please attach/provide all results

Since the start of your ill health has anything happened to make matters significantly better?

What do you do that makes you feel worse? _____

What do you do that makes you feel better? _____

Birth History

Did your mother have pregnancy complications?

Were there birth complications?

How many days were you in the hospital when you were born? _____

Childhood and Adolescent History

What illnesses did you have as a child?

Did you receive vaccinations as a child? _____

What were they for?

About how many times did you take antibiotics as a child? _____

What were they for?

What regular medicines did you take as a child? _____

What were they for?

Please explain any hospitalizations as a child (<18 years old):

Please explain any health problems you experienced in high school:

Please explain any health problems while at school after high school **(College/Professional School)**:

Adult History

Please explain any other health issues as an adult that you feel are important for us to know:

Please list Surgeries and dates:

Do you have any surgical implants? What Material?

Please list hospitalizations and dates:

Environmental Exposure History

Where have you lived in the past?

Have you traveled outside of the United States? ☐ Yes ☐ No

When and where?

Do you or did you smoke? ☐ Yes ☐ No

Did you live with a regular smoker? ☐ Yes ☐ No

Have you lived where you drank well water?

☐ Yes: When and where? _____

☐ No

Have you had any exposure to man-made chemicals that you know of (cleaning chemicals, toxic metals, farm chemicals, hair care products, insecticides, paints and solvents, auto chemicals, welding, etc)?

Please explain:

How many times do you go to the dry cleaners in a month? _____

Currently are you bothered by any exposures like chemicals, fumes, cigarette smoke, perfumes, car exhaust, etc?

Please explain:

Have you had any head injury (unconscious, amnesia, concussion, headaches, seizures)?

Please explain:

Have you ever lived or worked where there was a musty odor, mildew, water leak or known mold growth?

Please explain:

Have you ever lived somewhere that you believe made you ill?

Please explain:

Have you ever been told you have an ongoing infection or parasite illness? (By whom, what, when?)

Please list all previous bites, reactions, and dates:

Diet and Nutrition History

Current height in inches: _____ Current weight in pounds: _____

Heaviest weight since age 18: _____ Lightest weight since age 18: _____

What is your desired weight range goal in pounds? _____

Have you ever changed your diet or eating habits due to health concerns? Please explain

Are you currently on a special diet or eating program?

Do you feel that you have problems with your digestion? Please explain:

Do you regularly perform any digestive “cleanses”?

How willing are you to modify your eating to achieve your wellness goals?

☐ Not willing ☐ Somewhat willing ☐ Very willing

What foods or beverages do you consume the most?

What changes to your eating habits do you think you should make to feel better?

_____

Are there any barriers to changing your eating habits?

_____

Exercise and Stress Reduction

Are your health problems made worse by stress? ☐ Yes ☐ No

Please list significant sources of stress in your life:

_____

Do you get regular physical exercise? Please describe (what kind, how often, what duration, when and where):

_____

Do you engage in any regular stress reduction activity (meditation, yoga, prayer, etc)?

☐ Yes – Please Explain: _____

☐ No

Have you ever received counseling or special care for your mental health?

☐ Yes – Please Explain: _____

☐ No

Would you consider working with a trainer or life coach? ☐ Yes ☐ No

Are you under excessive stress and what are the sources of your stress? ☐ Yes ☐ No

Please grade your stress level: 0 = No Stress, 10 = Most Stress Imaginable, NA = Not Applicable

Home _____ Spouse _____ Children _____ Parents _____ Job _____ Social Life _____

Girlfriend/Boyfriend _____ School _____ Sexual Relations _____

Have you ever had professional help to cope with stress?

☐ Yes – Please Explain: _____

☐ No

Please list ways you have learned to cope with stress:

_____

_____

Other Social History

Do you currently smoke?

☐ Yes – How much? _____

☐ No– When did you quit (if applicable)? _____

Did you live with someone who smoked?

☐ Yes – For How long? _____

☐ No

If you smoke how likely are you to quit if advised to do so?

☐ Not at all likely ☐ Somewhat likely ☐ Very likely ☐ I plan to quit smoking

Have you been involved in a program to quit smoking in the past?

☐ Yes – Please Explain: _____

☐ No

Do you consume alcoholic beverages?

☐ Yes – What type, how much & how often?

_____

☐ No

Do alcoholic beverages help you to feel better? ☐ Yes ☐ No Feel worse? ☐ Yes ☐ No

Do you take any non-prescribed recreational drugs?

☐ Yes – What type, how much & how often?

_____

☐ No

If you do is it in order to feel better or get relief of symptoms? ☐ Yes ☐ No

For Women Only

Age at first period: _____ Date last period started: _____

Are your periods regular? ☐ Yes ☐ No How many days between periods: _____

Periods are: ☐ Light ☐ Moderate ☐ Heavy ☐ Very heavy

Do you experience symptoms that seem related to your cycle like PMS?

☐ Yes – Please explain:

_____

☐ No

Have you been pregnant? ☐ Yes ☐ No

If yes, how many times & what outcome? _____

During pregnancy did you feel: ☐ Better ☐ Worse ☐ Same

Did you experience significant problems from pregnancy or delivery?

☐ Yes – Please explain:

_____

☐ No

What form of contraception do you employ?

_____

☐ None / Not applicable

Do you use oral contraceptives or female hormones?

☐ Yes – Please list:

_____

☐ No

Are you experiencing problems with sexual relations?

☐ Yes – Please explain:

_____

- For how long? _____

☐ No

Did you in the past?

☐ Yes – Please explain:

_____

- For how long? _____

☐ No

When did you have your last female exam? _____

Date of last PAP smear? _____

Date of last mammogram? _____ ☐ N/A

MEN ONLY

Any change in sexual performance? ☐ Yes ☐ No

Please check all that apply:

☐ Sex Drive ☐ Motivation ☐ Erection ☐ Climax/Orgasm ☐Pain

List any other:

_____

Any prostate problems or change in urination?

☐ Yes – Please explain:

_____

☐ No

Have you taken anything to assist with sexual performance or prostate health?

☐ Yes – Please explain:

_____

- For how long? _____

☐ No

List of Symptoms In Past 60 Days

Digestive: ☐ Abdominal Pain ☐ Belching ☐ Bloating ☐ Change in appetite

☐ Constipation ☐ Diarrhea ☐ Flatulence ☐ Heartburn ☐ Nausea ☐ Reflux

☐ Vomiting ☐ Upset Stomach

Endocrine: ☐ Acne ☐ Adrenal problem ☐ Change in hair ☐ Change in skin/nails

☐ Change in urine ☐ Diabetes/High blood sugar ☐ Eating disorder ☐ Excess Sleepiness

☐ Excessive sweating ☐ Fatigue ☐ Feeling cold/Chills ☐ Feeling Hot/Hot flashes

☐ Fluid retention ☐ Food cravings ☐ Hair loss ☐ Increased urination ☐ Low blood sugar

☐ Night sweats ☐ Not sweating ☐ Pituitary disorder ☐ Sleeplessness/Insomnia

☐ Thyroid problem ☐ Undesired hair growth ☐ Unusual body odor ☐ Weight gain

☐ Weight loss ☐ Other hormone disorder: _____

Nervous System: ☐ Absence spells ☐ Amnesia ☐ Burning/Tingling

☐ Change of muscle tone ☐ Concussion ☐ Confusion ☐ Facial pain ☐ Fainting episodes

☐ Faintness ☐ Hallucinations ☐ Head injury ☐ Headaches ☐ Hoarseness

☐ Loss of Coordination/Dropping things ☐ Migraines ☐ Muscle loss ☐ Numbness

☐ Problems with focus/attention ☐ Problems with memory ☐ Problems multitasking

☐Problems with speech

Problems with sensitivity to: ☐ Odors ☐ Sights ☐ Smells ☐ Sounds ☐ Tastes

☐ Seizure-like activity ☐ Tremors ☐ Uncontrolled movements ☐ Voice change

☐ Weakness

Vision: ☐ Blurred vision ☐ Change in colors ☐ Dark spots/tunnel vision

☐ Dry eye ☐ Itchy eyes ☐ Loss of vision ☐ Visual hallucinations/spots/flashes

Hearing/Balance: ☐ Disequilibrium ☐ Ear discharge ☐ Ear itching ☐ Ear pain

☐ Loss of hearing ☐ Motion sickness ☐ Positional vertigo ☐ Ringing in ears ☐ Spinning

☐ Vertigo

Nose/Sinuses: ☐ Nasal blockage ☐ Nasal discharge ☐ Nasal itching

☐ Nosebleed ☐ Post-nasal drip ☐ Sinus pain ☐ Sneezing ☐ Sinus infection

Mouth/Throat: ☐ Dry mouth ☐ Growth or sore ☐ Mouth pain/burning

☐ Mouth swelling ☐ Trouble swallowing

Mood/emotions: ☐ ADD/ADHD ☐ Addiction ☐ Anxiety Panic attacks

☐ Autism ☐ Bipolar Psychiatric diagnosis ☐ Compulsive ☐ Depression

☐ Emotionality Schizophrenia ☐ Excess fear/Phobia ☐ Impulsive ☐ Obsessive

☐ Mood swings ☐ Tantrums/Rages ☐ Trouble with transitions

Immune/Inflammatory: ☐ Auto Immune Disorder (Please list): _____

☐ Frequent illness ☐ Food allergy ☐ History Mononucleosis ☐ HIV

☐ Lyme ☐ Parasites ☐ Seasonal Allergy/Hay fever ☐ Shingles

Respiratory: ☐ Asthma ☐ Bronchitis ☐ Cough ☐ Coughing up blood ☐ Emphysema

☐ Pneumonia ☐ Shortness of breath ☐ Sleep apnea ☐ Tuberculosis

Skin: ☐ Eczema ☐ Hives ☐ Excessive bruising ☐ Rash

☐ Persistent sore/growth/mark

Cardiovascular: ☐ Blood clot ☐ Chest pain ☐ Cholesterol/Lipid disorder

☐ Cold extremities ☐ Exercise intolerance ☐ Exertion pain ☐ Heart attack

☐ High blood pressure ☐ Irregular heart beat ☐ Lightheadedness

☐ Low blood pressure ☐ Mitral valve prolapsed ☐ Pain with exercise ☐ Rapid heart beat

☐ Slow heart beat ☐ Sudden vasospasm ☐ Stroke ☐ TIA

Joints and Extremities: ☐ Joint pain ☐ Joint redness ☐ Joint stiffness

☐ Joint swelling ☐ Hot joints ☐ Muscle pain ☐ Muscle spasm

☐ Muscle swelling ☐ Muscle tenderness to touch

GenitoUrinary: ☐ Bedwetting ☐ Blood in urine ☐ Burning urination

☐ Change in urine smell ☐ Change in urine appearance ☐ Frequent/Urgent urination

☐ Nighttime Urination ☐ Uncontrolled urination/Incontinence

Dental: ☐ Bleeding gums ☐ Broken teeth ☐ Dental cavities

☐ Gum disease ☐ Mercury fillings ☐ Metal crowns/Implants ☐ Pain with chewing

☐ TMJ disorder/pain ☐ Tooth pain

Family History (Please check all conditions occurring in your family)

☐ ADD/ADHD ☐ Addiction Disorder/Alcoholism ☐ Allergies ☐ Arthritis

☐ Asthma ☐ Autistic Spectrum ☐ Bleeding Disorder

☐ Auto Immune Disease (Please list which family member(s) and what diagnosis):

☐ Cancer (Please list which family member(s) and what diagnosis):

☐ Celiac Disease ☐ Chronic Fatigue ☐ Depression/Anxiety ☐ Diabetes

☐ Dementia/Alzheimer's ☐ Digestive Disorder ☐ Dizziness/Vertigo

☐ Eczema/Psoriasis ☐ Fibromyalgia ☐ Food Allergy

☐ Headache/Migraine ☐ Heart Disease ☐ High Blood Pressure

☐ Hormone Balance ☐ Immune Deficiency ☐ Inherited/Metabolic Disorder

☐ Inflammatory Bowel Disease ☐ Irritable Bowels ☐ Memory Loss

☐ Mitochondrial Disorder ☐ Multiple Sclerosis ☐ Nerve Disorder ☐ Overweight

☐ Parkinson's ☐ Psychiatric Disorder ☐ Seizures ☐ Skin Disease

☐ Sleep Apnea ☐ Sleep Loss ☐ Thyroid Problems