

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

_____ 2" wide & 6+" length

_____ 1" wide & 4+" length

_____ thin, long or narrow

_____ small, hard

_____ large, hard

_____ difficult to pass

Stool consistency

_____ float like a submarine

_____ float on top of water

_____ sink to bottom

_____ loose but not watery

_____ diarrhea

_____ alternate hard/diarrhea

Stool color

_____ med/dark brown

_____ very dark/black

_____ yellow/tan/clay

_____ greenish

_____ blood is visible

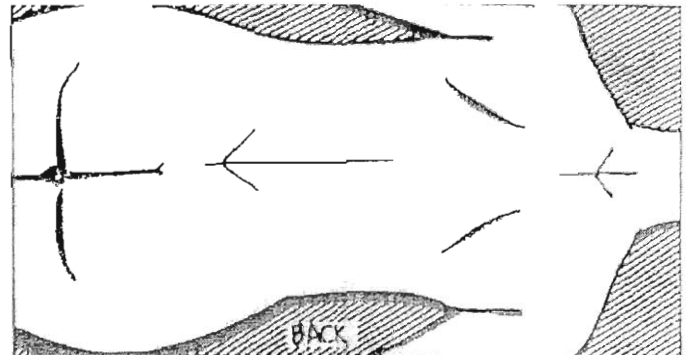
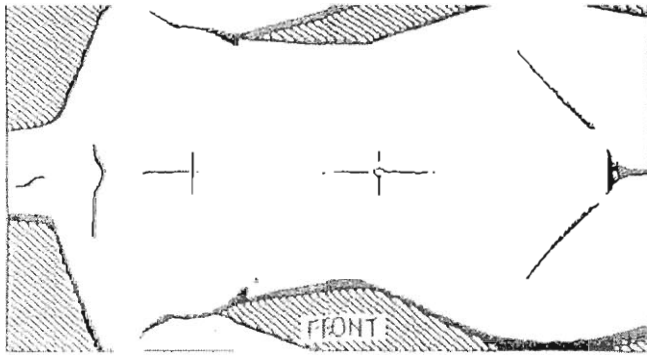
_____ mucous in/around

() 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

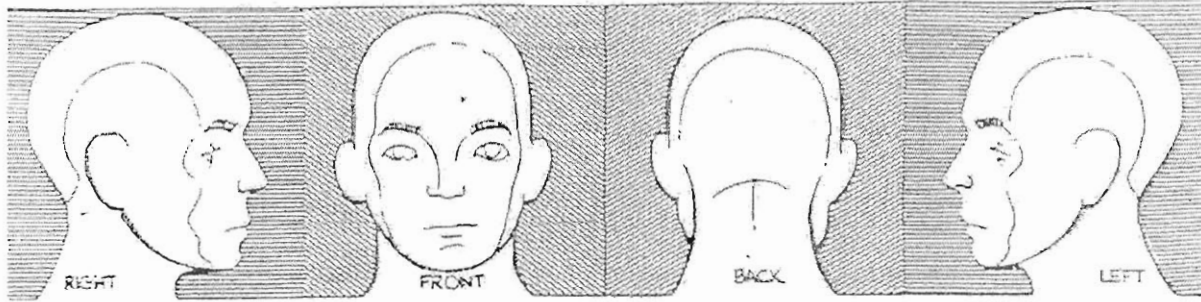
() no odor () some odor () odor usually () fowl smelling

() 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: coarse 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

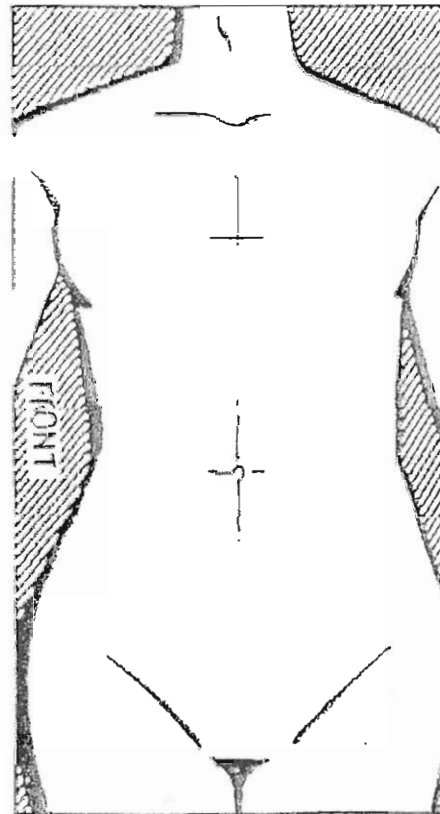
I have: high blood pressure low blood pressure

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

Male Specific

I am: overly tired exhausted getting too old for anything impotent

My prostate: normal enlarged had cancer removed date last prostate exam _____

date last blood PSA _____ result / number _____

I have: pain on urination difficulty starting urine flow difficulty stopping urine flow

dribbling of urine decreased stream size pain or pressure after sex

get up to urinate _____ times per night burning discharge

My urine color: pale yellow bright yellow dark yellow other _____

clear cloudy w/mucous varies a lot

My urine has: odor describe _____

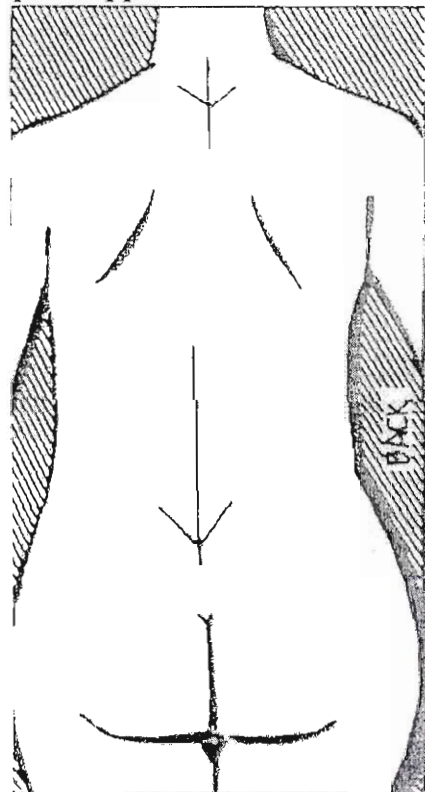
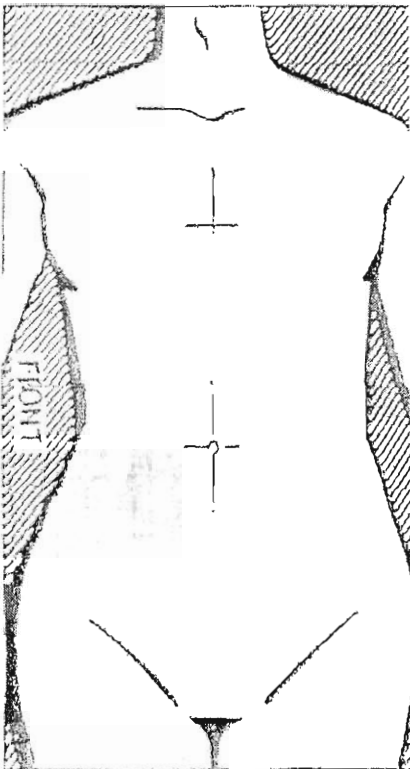
I have: _____ hernia pain in testicles or scrotum
where

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

ALL PATIENTS: Use the diagrams below to mark all areas of pain or discomfort you have experienced in the past 90 days. Describe your pain/discomfort in the margins and connect with arrow to each area the description applies to.



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 _____