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This questionnaire is to help you and I understand your health concerns. If you prefer not to answer any questions do not mark them. You are not obligated to complete this form; however, a Consultation may not be available in the absence of this information.

Name:_____ Date:_____

Address: _____

Home Phone: _____ Cell phone: _____

E-mail: _____

Date of Birth: _____ Age: _____ Male/Female: _____ Height: _____

Weight: _____ Relationship Status: _____ Children: _____

Occupation:_____

Please check the types of health care practitioners you have seen or are seeing:

____ Chiropractor	____ Naturopath	____ Psychiatrist	____ Other _____
____ Counseling	____ Massage therapist	____ Psychologist	____ Social Worker
____ Herbalist	____ Medical doctor	____ Occupational therapist	____ Homeopath

Main Reason for this visit (Medical diagnoses, main complaints and symptoms):

_____

_____

Expectations for this visit: _____

_____

Other current / ongoing health issues: _____

Please list your Current (C) and Previous (P) Medications and Treatments:

c/p _____ ____ _____

____ _____ ____ _____

____ _____ ____ _____

____ _____ ____ _____

Have you had any recent blood work? If so, please attach a copy of your current blood work.

Do you exercise? _____ What kind? _____ How often? _____

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PART 2 - Hospitalization

Have you ever been hospitalized? When? Why? _____

_____

_____

Have you ever had surgery? What For? Why? _____

_____

_____

_____

_____

PART 3 - Family History

Please check condition if any member of your family has/had the following:

____ Cancer ____ High blood pressure ____ Diabetes I or II ____ Heart disease
____ Low blood pressure ____ Other _____

Have you used Recreational Drugs in your past? _____

PART 4 - Health History

Please enter C if current, or X for having experienced in the past. Leave blank if neither.

____ ADD or ADHD	____ Epilepsy	____ Male health problems
____ AIDS	____ Epstein-Barr Virus	____ Memory loss
____ Alcoholism	____ Excess stress	____Menopause Problems
____ Allergies	____ Eyesight Problems	____ Menstrual irregularities
____ Anemia	____ Fatigue	____ Numbness
____ Anxiety	____ Gynecological Problems	____ Painful joints
____ Arthritis	____ Headaches	____ Rashes
____ Asthma	____ Hearing Problems	____ Respiratory Problems
____Bloating	____ Heart Disease	____ Seizures

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PART 4 - Health History, continued

____ Cancer	____ Hepatitis A, B or C	____ Shingles
____ Chemical Sensativities	____ High Blood Pressure	____Shortness of Breath
____ Chronic Fatigue	____ HIV	____ Sleep Problems
____ Common Cold (Frequently)	____ Hyperglycemia	____ Sore Throats (Frequently)
____ Constipation	____ Hypoglycemia	____Stiffness
____ Diabetes I or II	____ Immune Disorders	____ Stomach Aches
____ Diarrhea	____ Injuries	____ Swelling
____ Dizziness	____ Low Blood Pressure	____ Tumors
____ Environmental Sensitivities	____ Urinary Tract infections	____ Other _____

PART 5 - Childhood Diseases and Illnesses

Please enter C if Current, or X for having experienced in the past. Leave blank if neither.

____ Allergies	____ Mononucleosis	____ Whooping Cough
____ Asthma	____ German Measles	____ Mumps (Pertussis)
____ Atopic Eczema (Rubella)	____ Rheumatic Fever	____ Bronchitis
____ Chicken Pox	____ Measles	____ Tonsillitis
____ Other _____		

PART 6 - Cardiovascular Health

Please enter C if Current, or X for having experienced in the past. Leave blank if neither.

____ Angina
____ Arrhythmias
____ Arteriosclerosis
____ Bruises Easily
____ Capillary Fragility
____ Cardiac Arrest
____ Chest pains
____ Cholesterol
____ Congenital deformities
____ Congest. Heart Failure
____ Edema
____ Fast Heart Beat
____ High Blood Pressure
____ Heart Attack
____ Heart Flutter
____ Heart irregularities
____ Hear Murmur
____ Low Blood Pressure
____ Mitral Valve Prolapsed
____ Palpitation
____ Poor Circulation
____ Rheumatic Fever
____ Slow Heart Beat
____ Stroke
____ Varicose Veins
____ Other _____
_____
_____
_____

Blood Pressure (avg.) _____ Resting Pulse Rate: _____

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PART 7 - Headaches and Migraines

Do you have headaches? [Y]/[N] _____ How long have you had them? _____

Headache triggers? _____

Seasonal Headaches? _____ Menstruation Headaches? _____

Headache pain 1 to 10_____ What other symptoms accompany your headaches? _____

_____

Medicines used or treatments tried for headaches; describe how they worked:

_____

PART 8 - Ears

Please enter C if Current, or X for having experienced in the past. Leave blank if neither.

____ Ear infections	____ Overly sensitive	____ Other _____
____ Earaches	____ Tinnitus / Ringing	_____
____ Hearing Loss	____ Wax Build-up	_____

PART 9 - Digestion

Please enter C if Current, or X for having experienced in the past. Leave blank if neither.

____ Anorexia Nervosa
____ Belching
____ Bulimia
____ Bowel Habit Changes
____ Crohn's Disease
____ Constipation
____ Diarrhea
____ Other _____
____ Dysentery
____ Eating Disorders
____ Flatulence
____ Food Unappetizing
____ Gallstones
____ Heartburn
____ Hemorrhoid
____ Irritable bowel syndrome
____ Diverticulitis
____ Large Appetite
____ Liver Problems
____ Low Appetite
____ Nausea
____ Pain After Eating
____ Stomach aches
____ Sudden Weight Change
____ Ulcer
____ Ulcerative Colitis
____ Vomiting
____ Indigestion
____ Parasites

Bowel Movements:

How often? _____ How many times a day? _____

Is it difficult to go? _____ How soon after a meal? _____

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PART 10 - Immune System

Please enter C if Current, or X for having experienced in the past. Leave blank if neither.

____ Allergies	____ Hashimoto's Thyroiditis	____ Lowered Resistance	____ Sick Often
____ Autoimmune Disorder	____ Heal Slowly	____ Lupus	____ Sore Throats
____ Catch Everything	____ Immunodeficiency	____ Mononucleosis	____ Swollen Lymph
____ Chronic Fatigue	____ Infections	____ Rheumatoid Arthritis	____ White Blood Cell Count
____ Enlarged Spleen	____ Infections	____ Other _____	

PART 11 - Endocrine System

Please check next to all that apply to you.

Hormonal Imbalance
____ Irritability and mood swings
____ Worsening PMS
____ Headaches
____ Sleep problems
____ Irregular periods
____ Heavy bleeding
____ Problems with uterine fibroids
____ Hot flashes and night sweats
____ Breast tenderness, cysts, or nipple discharge
____ Decreased libido
____ Joint pain or stiffness
____ Vaginal dryness
____ Dry eyes
____ Skin changes
____ Heart palpitations

Adrenal Imbalance
____ Difficulty getting up in the morning
____ Never feeling well-rested, even after sleep
____ Nocturnal waking
____ Anxiety, nervousness, mild depression
____ Lightheadedness on standing
____ Low blood pressure (hypotension)
____ Salt cravings
____ Reliance on sugar and caffeine to bolster flagging energy prefer protein salt and fat
____ Problems coping with stressful situations
____ Frequently feeling angry and frustrated
____ Struggling to get through the day, but feeling better after an evening meal
____ Frequent infections
____ Abdominal weight gain
____ Hair loss/men front of lower leg
____ Acne

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PART 11 - Endocrine System, continued
Adrenal Imbalance, continued

Please check next to all that apply to you.

____ Cold intolerance – not pronounced
____ Lack of mental focus, decreased productivity, absentmindedness
____ Feeling like everything's "too hard"
____ Constipation with bouts of diarrhea
____ Second wind around 11pm
____ Tired around 9pm but can push through it
____ Weight loss possible but gradual
____ Menstrual cycles heavier in beginning but decrease by 3rd day and spotty after

When are your highest and lowest energy levels of the day?
_____

Have your energy levels changed at any point and did something trigger the change? (e.g. emotional, physical)
_____

Hyperglycemia

____ Dry Mouth
____ Increased thirst
____ Hunger
____ Fatigue
____ Confusion
____ Nausea and Vomiting
____ Abdominal Pain
____ Shortness of breath
____ Fruity-smelling breath
____ Blurry Vision
____ Dizziness
____ Headache

Hypoglycemia – these feelings come when I've missed a meal or have not eaten.

____ Trembling/Shakiness
____ Heart racing
____ Sweating, chills, clamminess
____ Anxiety
____ Intense hunger
____ Nausea
____ Numbness/tingling
____ Drowsiness
____ Blurry vision
____ Dizziness
____ Headache
____ Difficulty Concentrating
____ Confusion

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PART 11 - Endocrine System, continued

Thyroid Function

Please check next to all that apply to you.

____ Brittle nails
____ Burning and prickling
____ Chronic boils
____ Chronic headaches- migraines, tension headaches
____ Cold intolerance
____ Cold skin
____ Decreased sweating
____ Depression
____ Excessive bleeding with periods
____ Eye pain- swelling eye lids, bulging eyes
____ Hair loss scalp and eye brows
____ Hearing disturbances
____ Hit a wall at 9:30
____ No second wind
____ Heart palpitations hoarseness
____ Irregular menstrual periods
____ Irritability
____ Labored or difficulty breathing
____ Loose stools
____ Loss of outer 1/3 of eyebrow
____ Low body temp.
____ Low blood pressure
____ Muscle aches and weakness
____ Infertility
____ Nervousness
____ No stamina increase
____ Obstinate constipation
____ Painful menstrual periods
____ Poor concentration
____ Poor equilibrium
____ Poor memory
____ Prefer sugary foods and caffeine
____ Repetitive infections-colds, tonsillitis, sinus infections, ear infections
____ Skin conditions- eczema, winter itch, fish skin, psoriasis
____ Swelling feet
____ Time you get up makes no difference
____ Tired all day/excessive fatigue
____ Slower heart beat
____ Weight gain in hips and thighs
____ Weight loss VERY difficult without treatment
____ Weight loss-difficult to gain weight

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PART 12 - Sleep

Please enter C for Current, or X for having experienced in the past. Leave blank if neither.

____ Fall asleep fast	____ Wake Often	____ Stay awake 'til 11 pm
____ Sleep through the night	____ Wake to urinate	____ Stay awake 'til 1 am
____ Hard to fall asleep	____ Restless sleep	____ Wake up at 3 am
____ Restful sleep	____ Hard to fall and stay asleep	____Other _____

DREAMS: (circle all that apply): Active, lucid, anxious, nightmares, probing, pleasant, scary.

How many hours do you sleep? _____

How many hours do you need to sleep to feel rested?_____

Do you feel rested in the morning when you wake up? _____

PART 13 - Allergies

Do you have allergies? _____ (If No, skip to Part 14)

What allergies?

_____
_____
_____
_____

When do your allergies act up?

_____
_____
_____
_____

Do you have allergic reactions to any drugs or herbal medicines?

_____
_____
_____
_____

What has helped your allergies?

_____
_____
_____
_____

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PART 14 - Respiratory

Please enter C if Current, or X for having experienced in the past. Leave blank if neither.

____ Asthma	____ Hay Fever	____ Tight around lungs	____ Bronchitis
____ Chest pain	____ Common Cold	____ Coughing	____ Difficulty Smelling
____ Flu	____ Fluid in Lungs	____ Laryngitis	____ Pleuritis
____ Respiratory	____ Runny Nose	____ Trouble Breathing In	____ Trouble Breathing Out
____ Wheezing	____ Tuberculosis	____ Oner _____	

Which season is the congestion at its worst?

_____

_____

Do you know of foods, environmental factors or situations that affect your breathing?

_____

_____

PART 15 - Urinary Tract

Please enter C if Current, or X for having experienced in the past. Leave blank if neither.

____ Bloating	____ Kidney/bladder stones	____ Urinary Tract Infections
____ Blood in Urine	____ Kidney Pain	____ Water retention
____ Burning Ruination	____ Lower Back Pain	____ Frequent Urge to Urinate
____ Strong-smelling Urine		

How many times a day do you urinate? _____

Do you wake up to urinate at night? _____ How many times? _____

Is it difficult to urinate? _____ Do you have frequent infections? _____

When you urinate do you still feel like you need to go? _____

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PART 16 - Diet

What do you drink most frequently and how much? _____

_____

What are your favorite foods that you eat often? ___ _____

_____

If possible, please record three consecutive days of what you eat and drink:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

END OF INTAKE QUESTIONNAIRE

- PLEASE REVIEW COMPLETED FORM WITH JUDI RYAN