Center for Well Being
3601 Minnesota Drive
Edina, MN 55435
Tel: 952-885-0822

Today's Date: _____

NEW PATIENT MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultation. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

Please fill out this form completely and bring it to your appointment. Failure to do so may result in a re-scheduling of the one hour appointment with the doctor.

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____

Cell Phone: (_____) _____- _____ month day year

Work Phone:(_____) _____-_____ Email address: _____

Living Status: __Single__Married _Div__Widow__Partner Place of Birth:_____

Occupation: _____ City or town & country if not US

Referred by: _____ Height: ___′ ____″ Weight: _____ Sex: _____

1. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Neck pain	Moderate	Chiropractic	Moderate to Excellent
a.			
b.			
c.			
d.			
e.			
f.			
g.			

2. Have you lived or traveled outside of the United States? Yes____ No____
   If so, when and where? _____
   _____

3. Have you experienced any major losses in life? Yes____ No____
   If so, please comment: _____
   _____
4. Previous jobs:
   _____
5. Recent medical physician: _____ Last seen? _____
6. Recent chiropractic physician: _____Last seen? _____

7. Past Medical and Surgical History:

	ILLNESSES	WHEN	COMMENTS
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn's Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		
	ILLNESSES	**WHEN**	**COMMENTS**
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		

aa. Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
ab. Back injury		
ac. Broken (describe)		
ad. Head injury		
ae. Neck injury		
af. Other (describe)		
DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag. Barium Enema		
ah. Bone Scan		
ai. CAT Scan of Abdomen		
aj. CAT Scan of Brain		
ak. CAT Scan of Spine		
al. Chest X-ray		
am. Colonoscopy		
an. EKG		
ao. Liver scan		
ap. Neck X-ray		
aq. NMR/MRI		
ar. Sigmoidoscopy		
as. Upper GI Series		
at. Other (describe)		
OPERATIONS	**WHEN**	**COMMENTS**
au. Appendectomy		
av. Dental Surgery		
aw. Gall Bladder		
ax. Hernia		
ay. Hysterectomy		
az. Tonsillectomy		
ba. Other (describe)		
bb. Other (describe)		

8. Hospitalizations:

WHERE HOSPITALIZED	**WHEN**	**FOR WHAT REASON**
a.		
b.		
c.		
d.		
e.		

9. How often have you have taken antibiotics?

	< 5 times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

10. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

11. What medications are you taking now? Include non-prescription drugs.

Medication Name	**Date started**	**Dosage**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Are you allergic to any medications? Yes____ No____

If yes, please list: _____

_____

12. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	**Date started**	**Dosage**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

13. Are you on a special diet? Yes____ No____

_____ ovo-lacto	_____ vegetarian	_____ Paleo
_____ gluten-free	_____ vegan	_____ other (describe):
_____ dairy-free	_____ blood type diet	_____

14. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
Yes____ No____

b. If yes, are these symptoms associated with any particular food or supplement(s)?
Yes____ No____

c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

_____

_____

15. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

16. Do you feel much **worse** when you eat a lot of :

_____high fat foods	_____refined sugar (junk food)
_____high protein foods	_____fried foods
_____high carbohydrate foods (breads, pastas, potatoes)	_____1 or 2 alcoholic drinks
	_____other _____

17. Do you feel much **better** when you eat a lot of :

_____high fat foods	_____refined sugar (junk food)
_____high protein foods	_____fried foods
_____high carbohydrate foods (breads, pastas, potatoes)	_____1 or 2 alcoholic drinks
	_____other _____

18. Does skipping a meal greatly affect your symptoms? Yes____ No____

19. Have you ever had a food that you craved or really "binged" on over a period of time?
Food craving may be an indicator that you may be allergic to that food. Yes____ No____
If yes, what food(s)? _____

_____

20. Do you have an aversion to certain foods? Yes____ No____
If yes, what foods? _____

21. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

22. Intestinal gas: _____Daily _____ Present with pain
_____Occasionally _____ Foul smelling
_____Excessive _____ Little odor

23. a. Have you ever used alcohol? Yes____ No____
b. If yes, how often do you now drink alcohol? ___ No longer drinking alcohol
___ Average 1-3 drinks per week
___ Average 4-6 drinks per week
___ Average 7-10 drinks per week
___ Average >10 drinks per week
c. Have you ever had a problem with alcohol? Yes____ No____
If yes, please indicate time period (month/year): from _____ to _____.

24. Do you use recreational drugs? Yes____ No____

25. Have you ever used tobacco? Yes____ No____
If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
If yes, what type of nicotine have you used? _____Cigarette _____ Smokeless
_____Cigar _____Pipe _____Patch/Gum

26. Are you exposed to second hand smoke regularly? Yes____ No____

27. Do you have mercury amalgam (silver) fillings? Yes____ No____

28. Do you have any artificial joints or implants? Yes____ No____

29. Do you feel worse at certain times of the year? Yes____ No____
If yes, when? _____spring _____fall
_____summer _____winter

30. Do odors affect you? Yes____ No____

31. Do you exercise regularly? Yes____ No____

If so, how many times a week?

1._____1x
2._____2x
3._____3x
4._____4x or more

When you exercise, how long is each session?

1._____ ≤15 min
2._____ 16-30 min
3._____ 31-45 min
4._____ > 45 min

What type of exercise is it?

_____jogging/walking
_____basketball
_____home aerobics
_____tennis
_____water sports
_____other _____

32. Family History

Do any of your family members have (or have they had) any of the following diseases or conditions?
Place the appropriate abbreviation next to the disorder:
M (mother) F (father) GP (grandparent) S (sibling)

____ Abnormal bleeding
____ Anemia
____ Arthritis
____ Asthma / hay fever
____ Bone disorders
____ Cancer
____ Chronic back pain
____ Chronic headaches
____ Diabetes
____ Dizziness
____ Other _____
____Gastrointestinal disorders
____ Heart problems
____ Heart murmur
____ Hepatitis / liver problems
____ High / Low Blood pressure
____ Kidney problems
____ Lupus
____ Nervous disorders
____ Obesity
____ Epilepsy

Medical Symptoms Questionnaire

Name _____ **Date** _____

Rate each of the following symptoms based upon your typical health profile for:
☐ *Past 30 days*

Point Scale
0 - *Never* or *almost never* have the symptom
1 - *Occasionally* have it, effect is *not severe*
2 - *Occasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	Total _____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	
		(does not include near or far-sightedness)	Total _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	Total _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	Total _____
MOUTH/THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	Total _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	Total _____
HEART	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	
	_____	Chest pain	Total _____

LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	Total _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	Total _____
JOINTS/MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	Total _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Compulsive eating	
	_____	Water retention	
	_____	Underweight	Total _____
ENERGY/ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	Total _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Poor concentration	
	_____	Poor physical coordination	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	Total _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	Total _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	
			Total _____

GRAND TOTAL *TOTAL* _____