Functional Health Questionnaire

Please complete the following Functional Diagnostic Questionnaire to the best of your ability. You may need family members to help supply information. Your thoroughness and accuracy in answering all appropriate questions will help Dr. Candy Lewis evaluate the root cause of your health concerns and determine an effective treatment program.

Note that we are interested in "so-called" minor as well as major body complaints or problems. We know that in many doctor's offices there is a tendency not to mention too many symptoms for fear that the doctor will take you for a hypochondriac. The rules in our office are different. We are interested in any odd or unusual message you get from your body, even though it may seem irrelevant and of no consequence to your health. These are useful clues in the kind detective work we do.

Questions maybe repeated in several areas on the form. This is done on purpose and aids in the evaluation process. Do not skip a question because you feel you have answered it somewhere else on the form.

Please include as much information as you can on this form. Please do not skip any questions.

Please fill out the form electronically.

Number of Sisters_____ (# deceased ____) Number of Brothers _____ (# deceased ____)

Child #1 Name_____ Age_____ Sex: Male ○ Female ○ Health Issues

Child #2 Name_____ Age_____ Sex: Male ○ Female ○ Health Issues

Child #3 Name_____ Age_____ Sex: Male ○ Female ○ Health Issues

Child #4 Name_____ Age_____ Sex: Male ○ Female ○ Health Issues

Child #5 Name_____ Age_____ Sex: Male ○ Female ○ Health Issues

With whom do you live?

Do you have any pets or farm animals? ○ Yes No ○ Where do they live? ☐ Indoors ☐ Outdoors ☐ Both

Have you ever travelled outside the United States? ○ Yes ○ No If so, where?_____

How much time have you lost from work or school in the past year? ☐ 0-3 day ☐ 4-15 days ☐ > 15 days

How many hours do you sleep at night? _____ What time do you usually go to sleep at night? _____

Do you feel rested upon awakening? Yes ○ No ○ Do you snore? Yes ○ No ○

Do you use sleeping aids? ○ Yes ○ No Describe any sleep problems you have:

Do you drink alcoholic beverages? ○ Never ○ Rarely ○ Monthly ○ Weekly ○ Daily

How many per week?

Do you drink caffeinated beverages? ○ Never ○ Rarely ○ Monthly ○ Weekly ○ Daily

How many per week?

Do you smoke cigarettes? ○ Never ○ Rarely ○ Monthly ○ Weekly ○ Daily Packs per week?

Do you have stress? ○ Yes ○ No Have you had stress in the past? Yes ○ No ○

Rate your stress from 1-10

What currently stresses you the most?

Exercise: ○ Never ○ Light ○ Moderate ○ Heavy Hours per week: Type

Physical Work: ○ Never ○ Light ○ Moderate ○ Heavy Hours per week: Type

Mental Work: ○ Never ○ Light ○ Moderate ○ Heavy Hours per week: Type