NEW PATIENT Pre-Appointment Questionnaire

Name: ______________________________ DOB: _________________

Reason for visit / Top health goals

____

____

____

Nutrition

Breakfast

- Example 1: ____

- Example 2: ____

Lunch

- Example 1: ____

- Example 2: ____

Dinner

- Example 1: ____

- Example 2: ____

Snacks

- Example 1: ____

- Example 2: ____

How much plain water do you get a day? ____

Physical activity? Explain:

____

____

Diet history (special diets, successes, failures):

____

____

When I eat ____ (foods), I feel

____ (symptoms).

Please circle the answers to the following questions:

Do you get sick often? YES or NO Explain: ____

In the last 12 months, have you taken an antibiotic? YES or NO If yes, explain reason : ______________

Do you have environmental allergies? YES or NO Are they seasonal? YES or NO

Do you use natural cleaning products? YES or NO

Do you use plastic food containers or ziplock? YES or NO

Do you consider your digestion to be a problem? YES or NO

Bloating? YES or NO If yes, give frequency: ____

Constipation? YES or NO If yes, give frequency: ____

(Women) **Are you pregnant or breastfeeding?** YES or NO **Have you been pregnant before?** YES or NO

(Women) Are you premenopausal (still having a period), perimenopausal or menopausal? ____________________

Pre-menopausal: How long is your cycle? ________________ How long does your period last? _________

Pre-menopausal: What was the date of when your last cycle started (day 1): ___________

Pre-menopausal: Do you have PMS symptoms (moodiness, bloating, headaches) before your period?______

Pre-menopausal: Are your periods painful with cramping and/or heavy bleeding? _______________

History of thyroid problems? YES or NO If yes, explain: ____

Rate your average daily stress levels (circle): Not stressed 1 2 3 4 5 6 7 8 9 10 Very stressed

How do you cope with stress? ____

Do you have daily pain? YES or NO If yes, explain: ____

Breathing issues? YES or NO If yes, explain: ____

Hours of sleep per night: ___________________________ **Do you feel rested in the morning?** YES or NO

Do you consider sleep to be a problem? YES or NO

Do you smoke, chew tobacco, drink alcohol or use recreational drugs? If yes, please provide details/how often:

____

What are the typical tasks you do on the job/at work (including any chemicals you may handle):

____

Please list any past diagnosis given:

____

____

____

Please list all symptoms you experience in the following categories (if any):

Ears, nose & throat:____

Immune system: ____

Gastrointestinal: ____

Skin: ____

Mental: ____

Endocrine (example: thyroid, diabetes/pancreas): ____

Reproductive: ____

Chronic disease: ____

Misc: ____

Have you any adverse reactions to any medications, food, spice, supplement, or chemical? If so, explain:

____

____

Prescription medications (type, dosage & reason for being on it)

- ____
- ____
- ____
- ____
- ____
- ____

Over the Counter (type, brand, dosage & reason for being on it)

- ____
- ____
- ____
- ____
- ____
- ____

Supplements (type, brand, dosage & reason for being on it)

- ____
- ____
- ____
- ____
- ____
- ____

Outside Specialists

- PCP:____
- OBGYN:____
- Cardiologtist:____
- ____
- ____