



WELCOME QUESTIONNAIRE

Today's Date _____

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Nickname or preferred name: _____ Marital Status: S M D W Other _____

Home / Mailing Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone: (_____) _____ Other Phone: (_____) _____

Email address: _____

Preferred method of contact: Cell Phone Email Other Phone Other: _____

Messages regarding my appointments or health concerns may be left on: Cell Phone Email Other Phone

Emergency Contact: _____ Relationship: _____

Primary Phone: (_____) _____ Other Phone: (_____) _____

Most of our patients are referred by a caring family or friend. Whom may we thank for referring you to our office? Or how did you hear about us? _____

Pagosa is a small town. In an effort to maintain confidentiality, please let me know if you would like to be addressed upon meeting in public or remain anonymous: _____

WELLNESS INFORMATION

Health Challenges / Concerns: Please list your current health challenges, or items you would like to address in order of priority:

1) _____

2) _____

3) _____

Successful care is made possible when we have a thorough understanding of your current situation. The nature of your responses to the following questions, as well as your thoughtfulness and honesty, will assist in my understanding of your goals and desires pertaining to your health.

Goals, Outcomes & Expectations: What are your goals & expectations for today's visit? _____

What are your long-term outcomes / goals & expectations for working together?

What is your present level of commitment toward addressing any underlying causes of your symptoms?

0% 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyles habits do you engage in regularly that you believe support your health?

What behaviors or lifestyles habits do you engage in regularly that you believe are harmful to your health?

What potential obstacles do you foresee in addressing lifestyle factors and in adhering to therapeutic protocols recommended?

GENERAL INFORMATION:

Height: _____ Weight: _____ Recent Weight Loss / Gain Amount: _____ lbs

Reason / method for weight loss / gain: _____

Are you trying to gain or lose weight? Please explain _____

Daily Activity: Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking/Moving Driving Other

How often do you get outside per week? _____ For how long (average time)? _____

Do you exercise outside? Y N Types of Activities: _____

Do you go outside barefoot? Y N Do you wear sunblock? Y N Do you drink water with activity? Y N

Recent Energy Level: (10 = highest) 1 2 3 4 5 6 7 8 9 10 Bedtime: _____ Awaken: _____

Average number of hours of sleep per night: _____ Do you work nights? Y N

Difficulty falling asleep? Y N Difficulty staying asleep? Y N Tired after full night's sleep? Y N

Number of Bowel Movements per day _____ Do you use coffee or other means to stimulate a movement? Y N

If your eating habits have recently changed, please complete the following questions with your OLD way of eating, and then explain in the space below each item, how your eating habits have changed.

What time do you eat **Breakfast**? _____ Breakfast beverages: _____

Usual Breakfast foods: (List at least 5) _____

Recent Changes? _____

What time do you eat **Lunch**? _____ Lunch beverages: _____

Usual Lunch foods: (List at least 5) _____

Recent Changes? _____

What time do you eat **Dinner**? _____ Dinner beverages: _____

Usual Dinner foods: (List at least 5) _____

Recent Changes? _____

What times do you eat **Snacks**? _____ Usual snacks: _____

Recent Changes? _____

Lightheaded / irritable when hungry? Y N Crave sugar / salt? Y N Fatigue after meals? Y N

Need coffee/sweets 3-5pm? Y N Past / current Eating Disorder? Y N Currently dieting? Y N

List the three healthiest foods you eat during the average week: _____

List the three "worst" foods you eat during the average week: _____

Do you have any dietary restrictions / allergies? Y N Please explain your current eating philosophy or plan: (vegetarian, gluten / dairy intolerance, Kosher, paleo, keto, weigh-watchers, carnivore, autoimmune paleo, etc.) _____

Do you watch TV / Movies / use a computer? Y N How many hours per day? TV: _____ Computer: _____

Do you use "blue light blocking" glasses or filters? Y N How many hours per day? _____

Do you wear corrective lenses? Y N Date of last check-up / prescription change? _____

Are you currently working? Self Employed Retired Part-Time Full-Time Caring for children or family Not working

Let go from work Type of work / industry: _____

Current Stress Level: Low Med High Very High Previous Stress Level: Low Med High Very High

Lifetime or recent stressful / challenging events (trauma?): _____

Have you ever been married or in a long-term relationship? Y N Length of Relationship _____

Have you ever been divorced or ended a long-term relationship? Y N How recently: _____

Do you have children? Y N Please list age & gender: _____

Women only – any pregnancy or birth complications? _____

Have you recently moved? Y N Please provide details: _____

Have you recently lost any close family members, friends or pets? Y N Please provide details: _____

Have you ever lived near farming, a golf course, powerlines, known chemicals in the water, soil etc? Y N Please provide details: _____

Were you born in, or have you ever lived in or travelled to a foreign country? Y N Please provide details: _____

Some health issues can be related to our familial nationality or heritage. Please list your family heritage below:

Mother's Family _____ Father's Family _____

What is your cultural upbringing? _____

Childhood Illnesses

Scarlet fever Diphtheria Rheumatic Fever Mumps Measles

Rubella Chicken pox Mononucleosis Pertussis

Immunizations

Polio Y N Diphtheria Y N Tetanus Y N

Pertussis Y N Measles/Mumps/Rubella Y N Other: _____

Adverse reaction to any vaccinations (even if mild) If yes, please explain: _____

Please answer all questions as completely and thoroughly as you can. Though some questions may not seem to pertain to your current concerns, they are very important to help formulate an understanding of your current situation, and possible treatment plan, as well as to make proper referrals if necessary.

Most Recent Exams: (dates) **General Physical:** _____ **Vision:** _____
Dental: _____ **Specialist:** _____ **Men PSA Screening:** _____
Women Only Ob/Gyn/PAP: _____ **Mammogram/Thermography:** _____
Are you currently under the care of any medical doctor? Please explain: _____

Are you currently receiving any of the following therapies? (Please check all that apply)

- Acupuncture Chiropractic Energy Medicine Herbal Medicine (Chinese or Naturopathic)
 Nutritional Therapy Spiritual Medicine Therapeutic Massage Other _____

Have you had covid-19? Y N Are you recovered? Y N Has anyone in your home or at work had covid-19? Y N

Have you received a covid vaccine? Y N Which version? _____ Please provide any additional details: _____

MEDICAL HISTORY: (C = Current / P = Past (more than 6 months ago) Please check all that apply

- | | | | | |
|--|---|---|---|---|
| P / C | P / C | P / C | P / C | P / C |
| <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Elbow/Hand Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Chest Pressure | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Teeth Grinding |
| <input type="checkbox"/> Clammy Hands | <input type="checkbox"/> Fainting | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Tingling in Feet |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Shakiness | <input type="checkbox"/> Tingling in Hands |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Feel Loss of Control | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Unusual lumps |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Urination Difficulty |
| <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Lump in Throat | <input type="checkbox"/> Slow Heart Rate | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fullness of Bladder | <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> Weak Muscles |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Headache | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Swallowing Pain | |

HEALTH & FAMILY HISTORY:

Mark an **X** for any conditions that **you**, or any of **your family members** have now or have had in the past:

	Self	Mother	Father	Sibling(s)	Paternal Grandparent	Maternal Grandparent
Alcoholism						
Alzheimer's Disease						
Anemia						
Autism (spectrum disorders)						
Cancer						
Cold sores						
Covid-19						
Deep vein thrombosis						
Depression/Anxiety						
Diabetes						
Dementia						
Eczema/Psoriasis						
Epilepsy						
Epstein Barr / mononucleosis						
Goiter						
Gout						
Heart disease						
Hepatitis A/B/C						
Herpes						
High Blood Pressure						
HIV/AIDS						
Lyme						
Parkinson's Disease						
Pleurisy						

Pneumonia						
Stroke						
Tumor(s)						
Ulcer(s)						
Other:						

ACCIDENTS: Have you been involved in any of the following types of accidents? (check all that apply)

- Automobile Motorcycle Bicycle Sports Playground Violence Other

Year (approximate)	Please describe (injuries, treatment, outcome)

INJURIES: Have you ever injured any of the following regions? (check all that apply)

- Head Neck Rib/Chest Back Pelvis/Hip Arm/Hand Leg/Foot

Year (approximate)	Please describe (injuries, treatment, outcome)

SERIOUS ILLNESSES / HOSPITALIZATIONS / SURGERIES: Please detail hospitalizations / serious illnesses / surgeries

Year (approximate)	Reason	Outcome

MEDICATIONS: Please list all medications you are currently or have recently taken (prescribed or over-the-counter)

Medication Name	Condition	Date Started	Prescribed By?

NUTRITIONAL SUPPLEMENTS: Please list all Vitamins and Nutritional Supplements you are currently or have recently taken

Supplement	Brand & Amount Consumed	Date Started	Prescribed by? (if applicable)

PREVIOUS MEDICATION HISTORY: Please list an approximate number of times you have taken antibiotics for illnesses, yeast infections, skin disorders (including acne), dental procedures, surgery etc. _____ Have you ever been on a long term antibiotic (1 month or more) or Intravenous (IV) ? Y N Have you ever taken probiotics? Y N

ALLERGIES / SENSITIVITIES: Please check and list all allergies / sensitivities

Food: Gluten Dairy Soy Nuts Other _____

Medications: _____

Seasonal/Latex/Other: _____

Have you taken oral steroids (Cortisone, Prednisone) If yes: _____

HABITS: Please include current and previous amounts

	Daily	Weekly	Monthly	Never	Amount
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soda/Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rec. Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

If you no longer consume the above, please note length of consumption and date stopped.

How much water / day	8+ cups	4-7 cups	2-4 cups	<8 oz
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many times a week do you eat out?: _____ How many times a week do you eat fish? _____

How many times a week do you eat raw nuts or seeds?: _____ Please list the types of oil you cook with or use for salad dressing etc. ? : _____

If you have any concerns or questions you would like to note here, or issues you think might be related to your health challenges, please do not hesitate to discuss any matter with Dr. Jacqui at any time.

Client Name (Printed)

Client Signature

Date

Parent and/or Guardian Printed

Parent and/or Guardian Signature