WELCOME QUESTIONNAIRE

Today's Date_____

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Preferred name or Nickname: _____ Gender identity:_____

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

Preferred Phone: (_____) _____ Preferred method of contact: ☐ Cell Phone ☐ Email

Email address: _____

Who do you live with? _____

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? _____

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 / might be harmful to your health or well being?

_____

_____

_____

What potential obstacles do you foresee in addressing lifestyle factors or any recommendations for your health concern(s)?

_____

_____

_____

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

Do you use anything to help you sleep?(or in the past) _____

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

Do you use stool softeners / laxatives / any other method to stimulate a movement? _____

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 eat fermented foods? Please list: _____

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: _____

_____

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: _____

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 _____

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

Please list any hormone replacement therapy, birth control, other hormones you have used / tried in the past: _____

_____

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	☐	☐	☐	☐	_____
Coffee	☐	☐	☐	☐	_____
Soda/Diet Soda	☐	☐	☐	☐	_____
Tobacco	☐	☐	☐	☐	_____
Rec. Drugs	☐	☐	☐	☐	_____

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

Any Additional Details

_____

_____

_____

	8+ cups	4-7 cups	2-4 cups	<8 oz
How much water / day	☐	☐	☐	☐

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