

**APPLICATION FORM & QUESTIONNAIRE**

**GENERAL INFORMATION (Please print)**

**Today's date** \_\_\_\_\_\_\_\_\_\_\_

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age** \_\_\_\_\_ **Sex (M,F)** \_\_\_\_\_\_

Place of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date \_\_\_\_\_\_\_\_\_\_\_\_

Marital status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of children \_\_\_\_\_

Living situation (alone, family, friends) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip/Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone** (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** (work/cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OPTIONAL**

*(sometimes it can help explain your health problem)*

Religion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMPREHENSIVE HEALTH HISTORY**

**YOUR CURRENT HEALTH PROBLEMS**

What is your major health problem?

What are the symptoms? (Location, quantity, quality, or severity, timing, setting in which they occurred, factors that aggravate them or relieve them and associated manifestations.)

When did it start for the first time and setting in which it developed?

Describe any factors that you suspect may have played a role in its onset and continuation.

Is it becoming better or worse? Be specific in your description.

Describe past treatments for this problem.

Drugs: How long and what dosage taken?

Surgeries:

Natural treatments:

What treatment worked the best?

What treatment worked the least?

Do you have any other health problems? Please list in order of importance and describe.

Do you have any emotional issues that you would like to address?

Do you have any sexual issues that you would like to address?

Do you have any social issues that you would like to address?

Do you have any family issues that you would like to address?

Are you currently working with

a doctor of conventional medicine \_\_\_ yes \_\_\_ no

a naturopathic doctor \_\_\_ yes \_\_\_ no

a counselor, pastor, or other therapist \_\_\_ yes \_\_\_ no

Today's weight \_\_\_\_\_\_\_\_\_\_ Today's height \_\_\_\_\_\_\_\_\_\_\_\_

As an adult what has been your maximum \_\_\_\_\_\_\_\_ and minimum \_\_\_\_\_\_\_ weight?

Any recent weight change?

Do you feel weakness or fatigue? Explain.

Do you have an exercise routine? Describe.

Do you have any allergies and/or drug allergies?

**YOUR HEALTH HISTORY:**

Is your present state of health \_\_\_ excellent, \_\_\_good, \_\_\_average, \_\_\_\_fair, \_\_\_ poor.

General state of health: rate today's state compared to the past. (Rate from 1 to 10; 1 is the lowest, 10 is highest.)

Now \_\_\_\_\_ In the past \_\_\_\_\_\_ Please comment.

When during the day is your energy the best? \_\_\_\_\_\_\_\_\_\_\_\_ Worst? \_\_\_\_\_\_\_\_\_\_\_\_

Rate your energy level: Now \_\_\_\_\_\_\_\_ In the past \_\_\_\_\_\_\_\_\_\_\_

Childhood illnesses:

\_\_\_measles \_\_\_rubella \_\_\_mumps \_\_\_whooping cough

\_\_\_chicken pox \_\_\_rheumatic fever \_\_\_\_scarlet fever \_\_\_polio

Childhood immunizations and age at immunization:

\_\_\_tetanus \_\_\_pertussis \_\_\_diphteria \_\_\_polio

\_\_\_measles \_\_\_rubella \_\_\_mumps \_\_\_influenza

\_\_\_hepatitus B \_\_\_hemophilus influenza \_\_\_pneumococcal vaccine

List adult illnesses, psychiatric illness, accidents, and injuries, operations,and hospitalizations by date of onset, starting with the oldest first:

Do you have any allergies to drugs, herbs, foods, animals, dust or other?

Have you been exposed to environmental hazards at home or on the job?

(Please read "Where do you find heavy metal toxicity?" at the end of this questionnaire and mention situations where you may have been exposed to mercury, cadmium, or lead.)

Do you live in a new place or an old one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you lived there? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it damp and moldy, or dry? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have new wall to wall carpeting? \_\_\_\_\_\_\_

Do you use aluminum cook pots? \_\_\_\_\_\_\_\_\_\_

Do you have an air filter at home? \_\_\_\_\_ At your job? \_\_\_\_\_\_

Do you live in a city, a suburban area, or in the country? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you live near a golf course or any area that is heavily sprayed with pesticides?\_\_\_\_

Do you work in the presence of toxic fumes or chemicals? \_\_\_\_\_\_

Do any of your hobbies involve toxic materials? \_\_\_\_\_\_

Are you presently exposed to secondhand smoke? \_\_\_\_\_\_ In the past? \_\_\_\_\_\_

If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_

What is the source of your drinking water?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any silver-mercury fillings? \_\_\_\_\_ How many? \_\_\_\_\_\_\_\_\_\_

What are your leisurely activities? Describe type and frequency.

What is the quality of your sleep? How many hours of sleep do you get on average?

Current medications, amount and dosage:

Vitamins, herbal remedies, and supplements:

Do you smoke tobacco? \_\_\_\_ Have you smoked in the past? \_\_\_\_

How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? \_\_\_ Have you drunk in the past?\_\_\_\_

How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:**

Age and health of parents, and if deceased, cause of death

Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brothers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sisters \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother's mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother's father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father's father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father's mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history of (indicate family member, severity, or death)

\_\_diabetes \_\_arthritis \_\_mental illness \_\_allergies

\_\_tuberculosis \_\_anemia \_\_drug addiction \_\_high BP

\_\_heart attack \_\_headache \_\_alcoholism \_\_hypoglycemia

\_\_cancer \_\_epilepsy \_\_depression \_\_stroke

Health of your children?

**DIGESTION AND ELIMINATION:**

**Gastrointestinal**

Do you have any problem with gas, bloating, or fullness after eating? \_\_Yes \_\_No

How Often? \_\_\_\_\_\_\_\_\_\_\_\_

How severe is the problem? (rate 1 to 10) \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_\_\_\_\_\_\_

How often do you have a bowel movement? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ever have blood, mucous, undigested food, or black stools? \_\_\_\_\_\_\_\_\_

Any rectal itching? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do your stools tend to be formed or loose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have diarrhea, constipation, alternating diarrhea and constipation? \_\_\_\_\_\_\_\_

Do you have thin, long, narrow stools? \_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have small, hard stools? \_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do your stools have a strong disagreeable odor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever fasted? \_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_

Was it supervised, or did you fast by yourself? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you traveled outside the USA in the last 5 years? \_\_\_\_\_\_\_\_\_\_\_

Have you gone camping in the last 5 years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Kidneys and Bladder**

Have you had recurrent bladder infections? \_\_\_\_\_

How were they treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any burning sensation during or after urination? \_\_\_\_

Is your urine dark yellow, bright yellow, pale yellow, cloudy, or clear? (circle)

Does your urine have a strong odor to it? \_\_\_\_\_\_

Do you perspire when you exercise? \_\_\_\_ Lightly, moderately, heavily. (circle)

Does your perspiration have a strong odor to it?\_\_\_\_\_\_\_

**MEDICAL SYMPTOMS RATING SCALE:  
  
Rate each of the following symptoms according to the following scale:   
0 never or almost never have this 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   
\_\_\_ swollen, reddened, or sticky eyelids   
\_\_\_ bags or dark circles under eyes   
\_\_\_ blurred or tunnel vision Total \_\_\_\_   
  
EARS   
\_\_\_ itchy ears   
\_\_\_ earaches or ear infections   
\_\_\_drainage from the ears   
\_\_\_ringing or hearing loss Total \_\_\_\_   
  
  
NOSE   
\_\_\_ stuffy nose   
\_\_\_ sinus problems   
\_\_\_ hay fever   
\_\_\_ sneezing attacks   
\_\_\_ excessive mucus formation Total \_\_\_\_   
  
MOUTH AND THROAT   
\_\_\_ chronic coughing   
\_\_\_ gagging, frequent need to clear throat   
\_\_\_ sore throat, hoarseness, loss of voice   
\_\_\_ swollen or discolored tongue, gums, or lips   
\_\_\_ canker sores Total \_\_\_\_   
  
SKIN   
\_\_\_ acne   
\_\_\_ hives, rashes, dry skin   
\_\_\_ hair loss   
\_\_\_ flushing, hot flashes   
\_\_\_ excessive sweating Total \_\_\_\_   
  
HEART   
\_\_\_ irregular or skipped heart beat   
\_\_\_ rapid or pounding heart beat   
\_\_\_ chest pain Total \_\_\_\_**

**LUNGS   
\_\_\_ asthma and/or bronchitis   
\_\_\_ chest congestion   
\_\_\_ shortness of breath   
\_\_\_ difficulty breathing Total \_\_\_\_   
  
DIGESTIVE TRACT   
\_\_\_ nausea and/or vomiting   
\_\_\_ diarrhea   
\_\_\_ constipation   
\_\_\_ bloated feeling   
\_\_\_ belching, passing gas   
\_\_\_ heartburn   
\_\_\_ intestinal and/or stomach pain Total \_\_\_\_   
  
JOINTS AND MUSCLES   
\_\_\_ pain or aches in joints   
\_\_\_ arthritis   
\_\_\_ stiffness or limitation of movement   
\_\_\_ pain or aches in muscles   
\_\_\_ feelings of weakness or tiredness Total \_\_\_\_   
  
ENERGY AND ACTIVITY   
\_\_\_ feelings of fatigue or sluggishness   
\_\_\_ feelings of apathy or lethargy   
\_\_\_ hyperactivity   
\_\_\_ restlessness Total \_\_\_\_   
  
MIND   
\_\_\_ poor memory   
\_\_\_ confusion, poor comprehension   
\_\_\_ poor concentration   
\_\_\_ poor physical condition   
\_\_\_ difficulty 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 \_\_\_\_**