The Connecticut Center for Health

New Patient Questionnaire – Second Visit

Please Fill Out & Return at Your Next Visit.

Date _____/_____/_____ Name: _____

BRING THIS COMPLETED FORM WITH YOU TO YOUR SECOND APPOINTMENT.

What is your present living situation? Please circle all that apply. Alone With Spouse With Parent(s) With Child or Children With Relative(s) With Friend(s) With Significant Other(s)

Do you have children? Yes or No Do your children live with you? Yes or No List your children by name and age.

_____

When did you last receive medical care? ____/____/____ Where? _____

What condition were you treated for? _____

Current Primary Care Physician? _____ Telephone _____

Address _____

How many times do you get colds, flues, sinusitis, sore throats, bronchitis or other infections annually? _____

How long do these usually last? _____ Are these conditions severe? Yes or No

Have you ever been diagnosed as having a worm or parasite infection? Yes or No If yes, when? ____/____/____

Have you ever suspected that you might be experiencing a worm or parasite infection? Yes or No

Do you camp outdoors? Yes or No Have you lived or traveled outside the United States? Yes or No

If yes, when and where? _____

Has any relative under the age of 60 died as the result of a heart attack? Yes or No Who? _____

Has any female in your immediate family experienced breast cancer? Yes or No Who? _____

PERSONAL EMOTIONAL HISTORY Please list the 5 most stressful events in your life in descending order of importance and indicate whether or not they are still impacting your life.

1 _____ Yes or No

2 _____ Yes or No

3 _____ Yes or No

4 _____ Yes or No

5 _____ Yes or No

Please list any **major decision(s) you are presently facing.** _____

_____

Please **list any major change(s)** in your life that you experienced recently or expect to experience in the near future.

_____

_____

Do you **presently experience** any of the following on a regular basis? Please circle all that apply.

Loneliness Sadness Crying Spells Depression Despair Suicidal Thoughts Fatigue
Tension Low Threshold for Frustration Anxiety Fear Panic Attacks Nightmares
Obsessive or Compulsive Behavior(s) Jealousy Possessiveness Shyness Inability to Communicate

When something troubles you, how do you deal with it? Please check the answer that best characterizes your response.

___ I don't. I deny or avoid it. ___ I deal with it independently, directly and privately.
___ I discuss it with a loved one. ___ I discuss it with a friend. ___ I discuss it with a clergy person or counseling professional.

Are you currently being or have you been **abused** in any way? (physical, emotional or sexual) Yes or No

Do you **love** yourself? Yes or No Don't Know Is it easy for you to **forgive** yourself and others? Yes or No

Is there **anyone in your life you have not forgiven** and harbor resentment toward? Yes or No If yes, please list.

_____

Rate your **self esteem** (circle) Very Low Low Moderate High Very High

Are you consulting a clergy person or counselor? Yes or No If yes, whom? _____

Do you own a gun or are there guns stored in your residence? Yes or No

Is another member of your household presently employed? Yes or No If yes, list the type of work this person does.

_____

Employer _____

Address _____

List your **hobbies , interests, and favorite leisure activities.**_____

_____

HOUSEHOLD Do you **live or work close to** any of the following types of areas? Please circle as many as you feel apply.
Busy Road Body of Water Wooded Area Power Lines Microwave Transmitter Smoke Stack
Dump Marsh Wetlands **Is your lawn or are neighboring lawns sprayed with chemicals?** Yes or No

Where do the electrical power lines attach to your home? (List closest room) _____

Do you have **house pets?** Yes or No If yes list _____

Are you **exposed to second-hand smoke?** Yes or No Do you **consume coffee?** Yes or No

How many cups of coffee do you consume daily? _____ What do you **put in your coffee?** _____

If yes, do you drink regular, decaffeinated or both? (circle) Regular Decaffeinated Both

Which **types of water** do you consume or cook with? (circle) City Tap Well Filtered Distilled Spring

How many glasses of water do you consume daily? _____ Is your water fluoridated? Yes or No

Do you **consume sugar** (in cakes, pies, candies, chocolate, ice cream, soda, junk food, etc.)? Yes or No

If yes, how many sugar treats per day _____ or per week? _____

Do you **consume sodas** containing caffeine? Yes or No If yes, how many cups do you consume daily? _____

Do you **consume teas**, either regular or iced? Yes or No If yes, how many cups do you consume a daily? _____

Do you sleep on an electrically heated waterbed? Yes or No Do you sleep under an electric blanket? Yes or No

How would you **characterize your energy on a daily basis?** (circle) Very Low Low Moderate High Very High

What is your average daily energy level on a 1-10 scale? (10 is high, 1 is low) _____

Do you spend time outside daily? Yes or No Do you feel that you have **adequate leisure time?** Yes or No

When you have leisure time, do you feel that you are **able to relax completely and enjoy it?** Yes or No

If no, please explain. _____

_____

When did you last take a vacation? ____/____/____ For what duration? _____

Have you ever been exposed to ***any kind*** of chemicals, solvents or toxic metals? Yes or No

Do you use a toothpaste or oral rinse containing fluoride? Yes or No

Do you use a deodorant with aluminum? Yes or No ***We recommend you don't.***

Do you use **mothballs?** Yes or No Do you use **chemical pest controls?** Yes or No ***We recommend you don't.***

Do you use laxatives? Yes or No If yes, what type(s)? _____ How often? _____

On average, **how often do your bowels move?** # of times daily. _____ # of times weekly _____

Characterize your stools? Use the following codes to denote frequency: ***I*** for Infrequently. ***F*** for Frequently.***C*** for Constantly.

	Small (6 inches or less in stool over a 24 hour period		Dark brown in color
	Medium (12 inches or more in stool over a 24 hour period		Black in color
	Large (18 inches or more in stool over a 24 hour period		Yellow, light brown or clay colored
	Loose but not watery		Green in color
	Diarrhea		Containing blood
	Alternatively hard and loose and/or watery		Containing mucus
	Medium brown in color		Containing undigested food

Do you have **intestinal gas?** If yes, is it : (circle) Occasional Frequent Excessive Painful Malodorous

Do you have **trouble initiating bowel movements** for which the stool is neither large nor hard? Yes or No

Do you experience **abdominal discomfort or cramping with bowel movements**? Yes or No

If yes, Please circle all that apply. Occasionally Frequently Always

Have you ever been diagnosed with a stomach, liver, gallbladder, pancreas, or bowel disease? Yes or No

Do you respond promptly to urges to defecate? Yes or No

PAIN SECTION (**Only complete this portion if pain is one of your chief complaints)**

List condition(s) in order of importance:	Date you first noticed:	Scale your pain - **"0" is none & "10" is severe**, circle the number None……to……..Severe	Circle the percentage that represents how much of the time you feel pain or your symptom(s) for the listed reason?
1.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
2.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51 75% 76-100%
3.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
4.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%

For each reason or condition listed above, please circle how it happened:

1. *Developed over time. *Illness. *Injury. *Auto accident. *Other_____. *Don't know.
2. *Developed over time. *Illness *Injury. *Auto accident. *Other_____. *Don't know.
3. *Developed over time. *Illness *Injury. *Auto accident. *Other_____. *Don't know.
4. *Developed over time. *Illness *injury. *Auto accident. *Other_____. *Don't know.

For each reason or pain condition, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (describe on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
1.	_____	_____	_____	_____	_____	_____	_____	_____	_____	
2.	_____	_____	_____	_____	_____	_____	_____	_____	_____	
3.	_____	_____	_____	_____	_____	_____	_____	_____	_____	
4.	_____	_____	_____	_____	_____	_____	_____	_____	_____	

Check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	normal	somewhat Limited	severely limited
Lifting	_____	_____	_____
Bending	_____	_____	_____
Standing	_____	_____	_____
Walking	_____	_____	_____
Sitting	_____	_____	_____
Climbing stairs	_____	_____	_____
Running	_____	_____	_____
Resting in bed	_____	_____	_____
Intercourse	_____	_____	_____
Computer work/typing	_____	_____	_____
Normal work	_____	_____	_____
Household activities	_____	_____	_____
Recreational activities	_____	_____	_____
Other (list below)			

Have you had Acupuncture previously? Yes or No What previous treatment have you received for this condition?

_____

_____

Please Check Whether Your Periods Are Regular or Irregular

____ **I HAVE REGULAR PERIODS:** Period every _____ days. Period lasts _____ days.

Number of Tampons or Pads Used Daily? _____ Date of Last Period? ____/____/____

____ **I HAVE IRREGULAR PERIODS:** Period usually every _____ days. Period lasts _____ days.

Number of Tampons or Pads Used Daily? _____ Date of Last Period? ____/____/____

Form of Contraception Used? _____ Number of Pregnancies? _____

Complications of Pregnancy _____

_____

Number of Births? _____ Number of Miscarriages? _____ Number of Abortions? _____

Are you currently pregnant and/or are you breast feeding_____

Complications Associated with Any of the Above _____

Age at Onset of Menopause? _____ Menopausal Symptoms _____

Date of **Last Pap** Smear? ____/____/____ Date of **Last Mammogram?** ____/____/____

Have You Ever Had An Abnormal Or Irregular Pap Smear? Yes or No When? ____/____/____

Have You Ever Had An Abnormal Or Irregular Mammogram? Yes or No When? ____/____/____

HEPATITIS C VIRUS SCREEN – Hepatitis C is an epidemic affecting more than 4 million people in the US. This is a virus that affects the liver and it is usually silent (without any symptoms) until the disease is advanced. Answering the following questions will us determine your possible risk of infection and if you should be tested.

Have you ever injected street drugs, vitamins or steroids? Yes or No When? ____/____/____

Have you ever received a blood transfusion or blood products? Yes or No When? ____/____/____

Have you ever received hemodialysis? Yes or No When? ____/____/____

Do you have any tattoos? Yes or No Do you have any body piercings? Yes or No

Have you ever snorted cocaine? Yes or No Is your steady sex partner Hepatitis C positive? Yes or No

Have any of your sex partners ever injected street drugs, vitamins or steroids? Yes or No When? ____/____/____

Have you ever had any sexually transmitted diseases such as gonorrhea, syphilis, chlamydia, genital warts, genital herpes? Yes or No When? ____/____/____

****

Do you have any root canals in your teeth? If yes, how many? _____

Do you have mercury silver fillings in your teeth? If yes, how many? _____