The Connecticut Center for Health

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New Patient Questionnaire

Date ____/_____/_____

PLEASE DO NOT MAIL QUESTIONNAIRE. BRING IT WITH YOU TO YOUR APPOINTMENT.

Last Name _____ First _____ Middle Initial _____ Age _____

Date of Birth ____/____/____ NickName _____ Gender_____ Pronoun Preferred_____

Address _____

City _____ State _____ Zip Code _____–_____

Home Phone _____ Cell Phone _____Work _____

Social Security Number _____–_____–_____ Email _____

What is your height? _____ Weight? _____ How did you learn about the Center?_____

Level of Education? (Check) ____ High School ____ College ____ Graduate School

Do you give us permission to share findings and converse with your primary doctor and other providers? ☐ Yes ☐ No

Primary Care Physician_____ Phone_____ Fax_____

Are you employed? Yes or No If yes, what is your occupation? _____

Employer _____

Address _____

Are you covered by medical insurance? Yes or No If yes, who? _____

Is this your **"primary**" insurance coverage? Yes or No

Your Insurance ID # _____ Group Name or # _____

Who's Name is the insurance in? (the subscriber) _____ ID# _____

Who will be responsible for payment of services? _____

Name of spouse, parent, relative, friend, or significant other _____

What health concern would you like to discuss in your initial visit?_____

Do you have other health concerns you would like to address at subsequent visits? List in order of importance.

1. _____ 3. _____

2. _____ 4. _____

What are your thoughts on these concerns? Do you have any ideas as to what might be the underlying cause of your symptoms?

_____

_____

_____

_____

When was the **last time you experienced optimal health?** _____

Please write the specific health results you would like to achieve in working with the doctor. _____

_____

_____

_____

_____

Have you ever been hospitalized? Yes or No If yes, please provide specifics where indicated below.

Condition Treated or Surgical Procedure Performed	Date	Hospital
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

Are you allergic to any foods, drugs or other substances? If yes, please list.

Food\Drug\Substance	Allergic Reaction(s)
_____	_____
_____	_____
_____	_____

Date of last physical exam? _____ Date of last chest x-ray? _____ Blood work performed? Yes or No

Do you smoke cigarettes? If yes number or packs per day _____

Do you use any other tobacco, vapor or e-cigarette products? List type/quantity_____

Are you exposed to second hand smoke? Yes or No

Do you have an alcoholic family member or loved one? Yes or No If yes, who? _____

Do you drink alcohol? Yes or No If yes list type/quantity_____

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? _____

Do you exercise? If yes, what type(s)? _____

If yes, times/week? _____ _____ How Long? _____

Do you use medical marijuana? If yes, what type/how often_____

Do you **use recreational drugs or marijuana**? If yes, what type/how often_____

Are you sexually active? Yes or No Do you use protection during sexual activity? Yes or No

Have you been screend for Hepatitis C? Yes of No

How many **hours do you sleep nightly?** _____ What time do you fall asleep? _____ What time do you awake? _____

How would you characterize your sleep? (circle) Fitful Erratic Calm Restful Deep

Upon awakening, do you feel well rested and energetic? Yes or No Do you nap during the day? If yes, how long? _____

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(s) were you treated for? _____

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 4 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

Please list any **major changes / decision(s) you are currently experiencing or will** 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? _____

_____

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.

_____

OCCUPATION If presently employed, how many hours per week do you work? _____

Describe the nature of your work and the responsibilities associated with it. _____

What is your **stress level at work** ? (circle) Non-Existent Low Mild Moderate High Severe

What is your **satisfaction level at work?** (circle) Non-Existent Low Mild Moderate High Extremely High

Do you work indoors? Yes or No Do you work in an office building? Yes or No

Do the windows open for ventilation? Yes or No Is there specialized air filtration in your workplace? Yes or No

Do you presently **work with chemicals or in the presence of toxic fumes?** Yes or No Have you ever? Yes or No

If Yes, list_____

What are you willing to do to achieve the health results you just recorded? If your physician were to recommend the following choices which would you be able to follow and comply with or not? Please check YES or NO.

ITEM	YES	NO	ITEM	YES	NO
Make dietary modifications			Take nutritional supplements daily		
Avoid certain foods			Be compliant with the treatment		
Exercise Regularly			Stick with the program for at least 6 months		
Read books, handouts or listen to tapes for self education about health			Keep the doctor informed about what part of the program is and is not working for you		

If you are in a relationship, will your **significant other support you** in your dietary or lifestyle modification(s)? Yes or No

Do you feel you are adequately loved by others? ☐ Yes ☐ No

Can you accept love when others offer it or demonstrate it? ☐ Yes ☐ No

Do you have people in your life that you love? ☐ Yes ☐ No

Do you experience joy and happiness on a regular basis? ☐ Yes ☐ No

Are you passionate about and fulfilled by some aspect of your life, such as work, a hobby, family, some combination of, etc.?

☐ Yes ☐ No List hobbies _____

Are you a “relaxed” person? ☐ Yes ☐ No Do you know how to relax? ☐ Yes ☐ No

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

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

_____

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 _____

Do you **consume coffee?** Yes or No # of cups 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 ounces 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 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

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

Please review this list of conditions, **CHECK ONLY THOSE ITEMS YOU ARE EXPERIENCING PRESENTLY.**

	Rough, Dry or Scaly Skin		Unexplained Fever		Unexplained weight gain or loss
	Psoriasis or Eczema		Burst of Energy following exercise		Overweight
	Itching Skin		Difficulty concentrating		Chronic Fatigue
	Pimples		Difficulty Sleeping		Increased thirst
	Brittle Nails		Difficulty Relieving Stress		Night Sweats
	Burning Skin				Wounds slow to heal
	Boils or Canker Sores		Dizziness		Swelling of Neck
	Skin Rash		Pain in Ears		Neck stiffness
	Skin Color Changes		Ringing in Ears		
	Hair Color Changes		Excessive Ear wax		Neck Pain
			Frequent Ear infections		Goiter
	Numbness		Discharge from Ears		Unusual Growths of Hair
	Paralysis		Loss of hearing		
	Loss of memory				Fever or Chills
	Lack of Coordination		Sore Gums		Intolerance to heat
	Nervousness		Sore Throat		Intolerance to cold
	Anxiety		Sore Mouth or Tongue		Excessive Hunger
	Depression		Sensitive Teeth		Inability to gain weight
	Mood Swings		Impairment /Loss of sense of taste		Change or loss of sensation
	Restlessness		Increase/Decrease of saliva		Loss of Balance
	Fitful Sleep		Persistent hoarseness		Seizures or Epilepsy
	Hallucinations		Difficulty speaking		Shaking or Trembling
					Lightheadedness upon standing
	Muscle Cramps		Dry Eyes		Severe Headaches
	Muscle Weakness		Damp Eyes		Fainting Spells
	Joint Pain, Stiffness/ Swelling		Caked or crusted eyelids		Trauma or Injury to the head
	Neck Pain		Sensitivity to Light		
	Upper Back Pain		Poor eyesight		Asthma
	Lower Back Pain		Cataracts		Emphysema
	Frequent Fracturing of Bones		Glaucoma		Bronchitis
			Changes in vision		Tuberculosis
	Abdominal Bloating		Double vision		Discharge from throat with blood/mucus
	Excessive lower bowel gas		Blurred vision		Chest Pain at rest
	Stomach pain 5-6 hrs from meals		Loss of vision		Chest Pain at play
	Symptoms relieved by drinking milk		Eye pain		Heart murmur
	Symptoms aggravated by worry/tension				Heart palpitation
			Post nasal drip		Swelling of Ankles
	Constipation		Sinusitis		Rheumatic Fever
	Diarrhea		Discharge from Nose		Sleep in an upright position
	Rectal Pain		Discharge from nose during/after meal		Frequently awake at night short of breath
	Hemorrhoids		Nose Bleeds		
	Jaundice		Difficulty breathing through nose		Frequent Urination
	Hepatitis		Impairment/loss of sense of smell		Frequent Night Urination
	Gall bladder problems		Frequent/Daily coughs		Frequent Urgent
	Difficulty swallowing		Frequent Colds		Painful Urination
	Vomiting		Shortness of Breath at rest		Difficulty Holding Urine
	Vomiting blood		Shortness of Breath at play		Frequent Urinary Infections
			Wheezing		Kidney Stones

	Loss of appetite				
	Frequently awake at night hungry		Frequent/Severe nausea		Black stools
	Irritable if late for a meal		Discomfort after fatty/greasy meals		Yellow stools
	Sudden cravings for sweets or alcohol		Lack of energy after meals		Blood in stools
	Headaches/tremors relieved by eating sweets.		Frequent heartburn/indigestion		Malodorous stools
			Frequent Stomach/Abdominal pain		Anal itching
	Swollen or Painful Lymph Nodes		Frequent/excessive belching		
	Easily Bruised				
	Bleeding				
	Anemia				

PERSONAL HEALTH HISTORY Please indicate any condition(s) of past or present concern:

PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION
___	___	Epilepsy	___	___	Seizures
___	___	Glaucoma	___	___	Sexually Transmitted Diseases
___	___	Gout	___	___	Sinusitis
___	___	Hay Fever	___	___	Stroke
___	___	Headaches	___	___	Thyroid (Hyper or Irregular)
___	___	Heart Attack	___	___	Tuberculosis
___	___	Alcoholism	___	___	Heart Disease
___	___	Anemia	___	___	Heart Murmur
___	___	Arthritis	___	___	High Blood Pressure
___	___	Asthma	___	___	Injury (Life-Threatening)
___	___	Bleeding (Excessive or Uncontrolled)	___	___	Kidney Disease
___	___	Cancer	___	___	Liver Disease
___	___	Constipation	___	___	Lyme disease
___	___	Diabetes	___	___	Mononucleosis
___	___	Digestive Disorders	___	___	Osteoporosis

PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION
___	___	Eczema	___	___	Pneumonia
___	___	Emphysema	___	___	Rheumatism
___	___	Epilepsy	___	___	Seizures
___	___	Glaucoma	___	___	Sexually Transmitted Diseases
___	___	Gout	___	___	Sinusitis
___	___	Hay Fever	___	___	Stroke
___	___	Headaches	___	___	Thyroid (Hyper or Irregular)
___	___	Heart Attack	___	___	Tuberculosis

FAMILY HEALTH HISTORY

Is any blood relative or member of your immediate family presently experiencing any of the following conditions? Please use the following codes to denote the person affected. ***M*** for your Mother. ***F*** for your Father. ***B*** for your Brother. ***S*** for your Sister. ***GM*** for your Grandmother. ***GF*** for your Grandfather. ***A*** for your Aunt. ***U*** for your Uncle. ***W*** for your Wife. ***H*** for your Husband. ***SO*** for your Significant Other.

PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION
___	___	Alcoholism	___	___	Heart Disease
___	___	Anemia	___	___	Heart Murmur
___	___	Arthritis	___	___	High Blood Pressure
___	___	Asthma	___	___	Injury (Life-Threatening)
___	___	Bleeding (Excessive or Uncontrolled)	___	___	Kidney Disease
___	___	Cancer	___	___	Liver Disease
___	___	Constipation	___	___	Lyme disease
___	___	Diabetes	___	___	Mononucleosis
___	___	Digestive Disorders	___	___	Osteoporosis
___	___	Eczema	___	___	Pneumonia
___	___	Emphysema	___	___	Rheumatism

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I hereby authorize the payment of medical benefits directly to my physician. I authorize my physician to release any information acquired in the course of my examination or treatment that may be required; by other medical professionals; by my insurance company and its agents to determine benefits payable for services rendered; and in a collection situation.

I understand and agree that I am ultimately responsible for the balance of my account for any and all professional services rendered on my behalf regardless of statements made by any/all insurance companies that I am/was a participating member. I understand that giving you my insurance information does not guarantee insurance approval or payment and I accept full responsibility for the payment of services if my medical insurance provider does not pay as well as late fees or service charges.

SIGNED _____ DATE _____/_____/_____
Patient, Parent or Guardian's Signature (if patient is a minor)

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