

# Connecticut Center for Natural Health

87 Bernie O'Rourke Drive, Middletown, CT phone: 860 347 8600 fax: 860 347 8434

## 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?**

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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 screened 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
___	___	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
___	___	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
___	___	Epilepsy	___	___	Seizures
___	___	Glaucoma	___	___	Sexually Transmitted Diseases
___	___	Gout	___	___	Sinusitis
___	___	Hay Fever	___	___	Stroke
___	___	Headaches	___	___	Thyroid (Hyper or Irregular)
___	___	Heart Attack	___	___	Tuberculosis

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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)