

**Medical Questionnaire**

*Please fill out this medical form to further evaluate your case and design your treatment plan. It will be sent to you via email once you book your treatment appointment. This information is strictly confidential and will not be shared with third parties.*

**Patient full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Weight: \_\_\_\_\_\_**

**Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please provide a form of ID ex. Driver’s license, Social Security, Passport**

**Emergency Contact:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relation to contact: \_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­\_\_\_\_\_­­­­­\_\_\_**

The following information about your health is very important. This will help me to help you get the results that you desire more rapidly, and more efficiently.

Please note that ALL information provided in this form will be kept confidential**.**

**Please state your 3 most important health priorities:**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List medications that you are currently or have recently taken (prescription, non-prescription, or vitamins).**

 **Name: Reason taking: Amount:**

* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
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**Organs Removed and/or Surgeries (e.g., tonsils, appendix, cancer surgery, hip/knee replacement, etc.)**

 **Description: Year: Reason:**

* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please mark if you have any of these medical conditions current or past:**

1. High blood pressure Yes No
2. Diabetes Yes No
3. Cancer Yes No
4. Heart irregularities or rapid pulse (tachycardia) Yes No
5. Brown spots or Age spots Yes No
6. Mental symptoms such as confusion, forgetfulness? Yes No
7. Frequent kidney infection or kidney problems Yes No
8. Arthritis Yes No
9. Cold, flu, infectious diseases Yes No
10. Swollen Ankles Yes No
11. Food allergies or Yes No
12. Severe Depression Yes No
13. High Cholesterol Yes No
14. Anxiety Yes No
15. Head Injury/Concussion Yes No
16. Sore gums (Gingivitis) Yes No
17. Numbness, burning in mouth and gums Yes No
18. 4 or more “silver” fillings Yes No
19. Root canals, if yes how many? \_\_\_\_\_\_\_\_ Yes No
20. A “metallic” taste in mouth Yes No
21. Ringing in the ears (Tinnitus)? Yes No
22. Numbness or unexplained tingling in arms and legs Yes No
23. Difficulty in walking (ataxia) Yes No
24. Candida-Related Complex or yeast infection/fungus Yes No
25. Constipation Yes No
26. Mucus in stools Yes No
27. Worked as a painter or in manufactory/chemical pesticide/fungicide factories Yes No

(Fungicides with methyl mercury or in pulp/paper/mills that used mercury Yes No

1. Have you experienced a weight loss of 10 or more pounds in the last 3 months? Yes No
2. Have you ever had kidney or bladder problems? Yes No
3. Do you smoke? Or are you exposed to secondhand smoke? Yes No
4. Do you drink alcohol? Yes No
5. Did you have the vaccinations? Yes No

What do you do for a living? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How quickly do you fall asleep at night? 5-10 min. 10-15 min. 15-25 min. 25-45 min Do you wake up at night? \_\_\_ What is the reason you wake up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate your stress level on a scale of 1-10: 1 2 3 4 5 6 7 8 9 10

Are you currently in treatment? Yes No

If yes, what was the outcome of the treatment?

What treatment did you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your daily diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately how much water do you drink a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you living with a partner? \_\_\_\_ Are you single? \_\_\_\_ Do you have children? \_\_\_\_\_\_

**Females**

Date of menstrual cycle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of cycle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_

Form of Birth Control\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Miscarriages: Yes No Abortions: Yes No

C-Sections: Yes No, Yeast infections: Yes No

Date of last physical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last gynecological: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ Date of last Pap test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Males**

Date of last physical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last colon exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last prostrate exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

Comments or Questions:

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**How important is your health to you? Scale of (1-10)** 1 2 3 4 5 6 7 8 9 10

**The above information is given to the best of my knowledge and I agree with the treatment that is suggested for me.**

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_