



2114 Schofield Ave. Weston, WI 54476

NUTRITIONAL PATIENT QUESTIONNAIRE

GENERAL INFORMATION – PLEASE PRINT

DATE ____/____/____

PATIENT NAME _____ HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

E-MAIL ADDRESS _____ @ _____ (We do not share your address)

DATE OF BIRTH ____/____/____ AGE ____ SEX M__ F__ MARITAL STATUS M__ S__ D__ W__

YOUR EMPLOYER _____ CITY _____

OCCUPATION _____ SSN ____-____-____

HOME PHONE (____) ____-____ WORK PHONE (____) ____-____ CELL (____) ____-____

SPOUSE'S NAME _____ BIRTH DATE ____/____/____ OCCUPATION _____

SPOUSE'S EMPLOYER _____ CITY _____ PHONE (____) ____-____

YOUR PRIMARY PHYSICIAN _____ DATE OF LAST PHYSICAL _____

DENTIST _____ DATE OF LAST VISIT _____

DATE OF LAST CHIROPRACTIC ADJUSTMENT ____/____/____ GIVEN BY _____

WHO SHOULD BE CONTACTED IN CASE OF EMERGENCY _____ PHONE (____) ____-____

WHO MAY WE THANK FOR REFERRING YOU TO US? _____ PHONE(____) ____-____

PLEASE FILL OUT THE FOLLOWING AS COMPLETELY AS YOU CAN. USE ADDITIONAL BLANK SHEETS AS NECESSARY. OBTAINING THE BEST POSSIBLE HEALTH HISTORY IS A PROCESS THAT CAN ONLY OCCUR WITH YOUR PARTICIPATION. THE INFORMATION YOU PROVIDE WILL HELP THE DOCTOR MAKE INFORMED RECOMMENDATIONS. THANK YOU.

HEALTH HISTORY

PLEASE GIVE THE PRIMARY REASON FOR YOUR CONSULTATION. BE SURE TO GIVE A DETAILED ACCOUNT INCLUDING WHEN AND WHY IT STARTED, WHAT HAS BEEN DONE TO DATE, THE RESULTS YOU HAVE HAD AND IF THE PROBLEM IS GETTING BETTER, WORSE OR STAYING THE SAME.

PLEASE LIST SECONDARY HEALTH PROBLEMS YOU ARE EXPERIENCING.

LIST ALL NUTRITIONAL SUPPLEMENT PRODUCTS YOU ARE CURRENTLY TAKING.

PLEASE BRING ALONG ALL BOTTLES WITH YOU TO YOUR CONSULTATION.

NAME COMPANY AMOUNT WHY TAKING HOW LONG?

LIST ALL PRESCRIPTION AND NON-PRESCRIPTION DRUGS YOU ARE TAKING AND ALL THAT YOU HAVE TAKEN IN THE PAST THAT YOU CAN RECALL.

NAME AMOUNT WHY TAKING HOW LONG? RESULTS

LIST ALL SURGERIES YOU HAVE HAD IN THE PAST.

SURGERY DATE WHY DONE RESULTS

LIST ALL ALLERGIES YOU HAVE TO FOOD, DRUGS OR OTHER SUBSTANCES.

ALLERGY SYMPTOMS HOW LONG?

ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

IF YOU DON'T KNOW THE ANSWER, JUST LEAVE IT BLANK.

() YES () NO MY MOTHER WAS HEALTHY WHILE PREGNANT WITH ME. IF NO, DESCRIBE _____

() YES () NO WAS YOUR BIRTH NATURAL? IF NO, PLEASE CHECK () FORCEPS () C-SECTION

() YES () NO WERE YOU BREAST FED FOR AT LEAST THE FIRST 6 MONTHS?

() YES () NO WERE YOU FED ANYTHING OTHER THAN BREAST OR COW MILK IN THE FIRST 6 MONTHS?

LIST ITEMS. _____

() YES () NO WERE YOU A COLICKY BABY?

() YES () NO HAVE YOU EVER BEEN TO OR LIVED IN A FOREIGN COUNTRY? LIST. _____

() YES () NO HAVE YOU EVER FAINTED OR HAD A CONVULSION? DESCRIBE. _____

MARK ANY YOU HAVE HAD: () MEASLES () HEPATITIS () HIV/AIDS () MONONUCLEOSIS

() MUMPS () VENEREAL DISEASE () SHINGLES () SCARLET FEVER

() LYMES () GERMAN MEASLES () HERPES () RHEUMATIC FEVER

() CHICKEN POX

DIET HISTORY

MARK EACH ONE AND GIVE THE AMOUNT YOU CONSUME (USING A "0" OR NONE WHEN APPROPRIATE).

_____ OUNCES WATER	_____ PER DAY	_____ PER WEEK
_____ OUNCES ALCOHOL	_____ PER DAY	_____ PER WEEK
_____ OUNCES COFFEE/TEA	_____ PER DAY	_____ PER WEEK
_____ OUNCES SODA	_____ PER DAY	_____ PER WEEK
_____ OUNCES JUICE	_____ PER DAY	_____ PER WEEK
_____ OTHER _____	_____ PER DAY	_____ PER WEEK

LIST YOUR 10 FAVORITE FOODS EATEN MOST FREQUENTLY.

GIVE PERCENTAGE FOR EACH OF THE FOLLOWING (TOTAL FOR EACH LINE SHOULD = 100%).

WHERE DIET PREPARED: _____ HOME _____ RESTAURANT _____ FAST FOOD _____ VENDING MACH

HOW PREPARED: _____ BAKED _____ BROILED _____ FRIED _____ STEAMED _____ MICROWAVED

PREPARED FROM: _____ FRESH _____ CANNED _____ FROZEN _____ PREPACKAGED

MY APPETITE IS: () NORMAL () EXCESSIVE () POOR () NONE

I CRAVE: () SWEETS () SALT () CHOCOLATE () WATER () DIRT () OTHER _____

TYPE OF WATER USED FOR DRINKING/COOKING: () TAP/CITY () SPRING () WELL
() REVERSE OSMOSIS () DISTILLED () FILTERED () RAIN

IF WATER IS PURCHASED, IS IT IN: () SOFT PLASTIC () HARD PLASTIC () GLASS

FOODS THAT DISAGREE WITH YOU: () RAW VEGETABLES () HIGHLY SPICED () RAW FRUIT
() MILK/DAIRY () FRIED () GREASY () EGGS () ONIONS
() BEANS () CABBAGE () SUGAR () OTHER _____

DESCRIBE THE SYMPTOMS YOU GET FROM FOODS THAT DISAGREE WITH YOU: _____

DO YOU FAST? () YES () NO IF YES, HOW OFTEN AND HOW LONG? _____

HAVE YOU EVER DONE A DEXTOXIFICATION PROGRAM? () YES () NO EXPLAIN _____

CHECK ANY OF THE FOLLOWING DIETS YOU HAVE EVER TRIED.

() LOW CHOLESTEROL () DIVERTICULITIS () COMPLEX CARB () HIGH PROTEIN
() LOW FAT () LOW SALT () LOW PURINE () ALL ENERGY
() ULCER () DIABETIC () RENAL/KIDNEY () HIGH FIBER

HOW MANY DAYS A WEEK DO YOU EXERCISE? _____ HOW LONG EACH TIME _____ TYPE _____

HEAD, MOUTH & THROAT

MY TEETH ARE: () SOME FILLINGS () BAD () SOME MISSING () ALL MISSING () ROOT CANAL
I WEAR DENTURES: () UPPER () PARTIALS () CROWNS () MORE THAN 1 TYPE OF METAL IN MOUTH
MY BREATH IS: () GOOD () SLIGHT ODOR () ODOR ON/OFF () OFFENSIVE ODOR USUALLY
MY TONGUE IS: () COVERED WITH SMALL TASTE BUDS () SORE () FURROWED () COATED _____ COLOR
MY TONGUE COLOR IS: () PINK () RED () RED BLOTCHY () PINK WITH RED TIP
MY TONSILS ARE: () NORMAL () REMOVED AT AGE _____ () ENLARGED () SPOTTED
MY SENSE OF TASTE IS: () NORMAL () POOR () NO TASTE () OVERSALT FOOD () CANKER SORES

MY LIPS ARE: () NORMAL () PEEL A LOT () FEVER BLISTERS OFTEN () CRACKED IN CORNERS

I GET HEADACHES: () DAILY () WEEKLY () RARELY () BEHIND EYES
() WAKE UP WITH () GET IN AM () GET IN PM
() BACK OF HEAD () FRONT OF HEAD () SIDE OF HEAD () NEVER
() WITH AURA () WITH SOME FOOD OR DRINKS
() OF DIFFERENT TYPES () WITH NAUSEA/VOMITING

MUSCLE, LIGAMENT, JOINT & NERVES

I HAVE PAIN IN: () NECK () MID BACK () LOW BACK () FEET
() HIP () KNEE () ANKLE () HANDS
() SHOULDER () ELBOW () WRIST () OTHER _____

I GET: () SWOLLEN JOINTS () SORE JOINTS () JOINTS POP/CRACK () JAW POPS
() LEG CRAMPS AT REST () LEG CRAMPS WITH ACTIVITY () WORSE AT NIGHT
() FOOT CRAMPS AT REST () FOOT CRAMPS WITH ACTIVITY () FLAT FEET
() BURNING FEET () TINGLING IN FEET OR HANDS () RESTLESS LEG SYNDROME

I HAVE: () NERVOUS TIC/TWITCHING – WHERE? _____ () BELL'S PALSY
() RINGING IN EARS () PARKINSON'S () SCIATIA () MULTIPLE SCLEROSIS
() HAD SPINAL SURGERY – WHERE? _____ RESULTS _____

HAIR, SKIN & NAILS

HAIR: () COURSE () FINE () FALLS OUT EXCESSIVELY () TURNED GREY AT AGE ____ () OILY () DRY
MALE BEARD: () HEAVY () LIGHT OR SPARSE () NONE () ETHNIC BACKGROUND _____
FEMALE: () FACIAL HAIR ALWAYS () FACIAL HAIR STARTED AT AGE ____ () HAIR ON ABDOMEN/BREASTS

FINGER NAILS: () NORMAL () BRITTLE/BREAK EASILY () SPOT () RIDGED VERTICALLY () WHITE SPOTS
() RIDGED HORIZONTALLY () GROW FAST () GROW SLOW () SHAPED ODDLY () HANGNAILS

SKIN: () NORMAL () OILY () DRY () FLAKY () ACNE () PSORIASIS () BOILS
() SMALL BUMPS ON UPPER ARMS () SKIN CANCER REMOVED ON _____ () SKIN TAGS
() ANTIBIOTICS FOR ACNE AT AGE ____ FOR HOW LONG? _____

SPOTS ON SKIN: () WARTS () MOLES () SMALL RED () LARGE RED () BROWN () WHITE

HANDS AND FEET: () DRY, CRACKED OR BLEEDING AREAS ON () HANDS () HEELS () FEET
() INGROWN TOENAILS () FUNGUS ON FEET OR NAILS () ATHLETE'S FOOT

CHEST & HEART

I HAVE CHEST PAIN THAT IS: () SHARP () DULL () SEVERE
() WORSE AT NIGHT () WORSE UPON EXERTION
() BETTER WITH EXERCISE () NO CHANGE WITH EXERCISE
() RADIATES TO MY ARM, NECK OR BACK

MY PULSE/HEARTBEAT IS: () TOO FAST () TOO SLOW () SKIPS BEATS

I HAVE: () HIGH BLOOD PRESSURE () LOW BLOOD PRESSURE

I AM: () ON HIGH BP MEDICATION () ON DIURETICS

I HAVE HAD: () HEART ATTACK () STROKE () ANGIOPLASTY () BYPASS SURGERY

I HAVE BEEN TOLD I HAVE: () HEART DISEASE () LUNG DISEASE () CLOGGED ARTERIES

I HAVE: () VARICOSE VEINS () SPIDER VEINS () HEMORRHOIDS () HAD VESSEL SURGERY

DESCRIBE ANY AREAS OF PAIN OR DISCOMFORT YOU ARE EXPERIENCING THAT YOU ASSOCIATE WITH
YOUR CHEST AND/OR HEART. _____

RESPIRATORY/LUNGS

I HAVE NASAL CONGESTION: () DAILY () SEVERAL TIMES PER WEEK () ONLY ON OCCASION

I HAVE NASAL DISCHARGE: () DAILY () SEVERAL TIMES PER WEEK () ONLY ON OCCASION
() CLEAR () YELLOW () GREEN () BLOOD () OTHER _____

I HAVE: () NON-PRODUCTIVE COUGH (NO MUCUS) () PRODUCTIVE COUGH (W/ MUCUS)
() ALLERGIES TO _____ () HOARSENESS OF VOICE () POST-NASAL DRIP
() HAYFEVER () ASTHMA () WHEEZING () SNORING

I HAVE/DID HAVE: () FREQUENT COLDS () FLU ONCE OR MORE A YEAR
() PNEUMONIA () SINUS INFECTION
() ANTIBIOTICS 3 OR MORE TIMES IN MY LIFE
() ALLERGIC TO _____

I TAKE: () ALLERGY SHOTS () ALLERGY MEDICATION () DECONGESTANTS () NASAL SPRAYS () STEROIDS

I USE: () CIGARETTES _____ PACKS/DAY () SNUFF/CHEW () CIGARS () EXPOSED TO 2ND HAND SMOKE

I HAVE BEEN TOLD I HAVE: () LUNG DISEASE _____ () EMPHYSEMA () COPD

EMOTIONAL & METABOLISM (MARK ALL THAT APPLY)

I AM/HAVE: () NERVOUS () ANXIOUS () DEPRESSED () SENSITIVE TO NOISE
() CONFUSED EASILY () SLEEPY DURING THE DAY () EXHAUSTED A LOT
() FATIGUE EASILY () LOSS OF APPETITE () RAGE () FEARFUL
() HEAR VOICES () WEAKNESS () POOR MEMORY () IRRITABLE
() MORBID THOUGHTS () SUSPICIOUS OF OTHERS () THOUGHTS OF SUICIDE
() QUICK MOOD CHANGES () FEAR OF INSANITY
() FEAR SERIOUS DISEASE LIKE _____ () AVOID CROWDS
() FRIENDS AVOID ME () HAVE LOW BLOOD SUGAR
() HAD GLUCOSE TOLERANCE TEST IT WAS () POS () NEG

I: () TAKE DAYTIME NAPS () DREAM TOO MUCH () HAVE NO DREAMS () HAVE NIGHTMARES
() WAKE UP TIRED () HAVE COLD FEET () FEEL TOO HOT
() HAVE COLD HANDS () AM COLD WHEN OTHERS ARE OK
() PERSPIRE TOO MUCH () HAVE INADEQUATE PERSPIRATION WHEN EXERCISING

DO YOU FEEL WELL RESTED WHEN YOU WAKE UP IN THE MORNING? () YES () NO

RATE OF QUALITY OF SLEEP. _____ (1 BEING AWFUL AND 10 BEING GREAT)

FEMALE SPECIFIC

MY MENSTRUAL () BEGAN AT AGE ____ () NORMAL () IRREGULAR
PERIODS ARE: () 2 OR MORE PER MONTH () FLOW IS EXCESSIVE () HAVE CLOTS
() FLOW IS SPARSE () REGULAR EVERY ____ DAYS
() NO PERIOD IN ____ MONTHS () ABNORMAL SINCE ____ YEARS OF AGE
() PAINFUL FIRST DAY () PAINFUL BEFORE AND DURING
() MENSTRUAL PROBLEMS () BEFORE OR () AFTER FIRST CHILD

MENSTRUAL BLOOD COLOR IS: () PINK () RED () BROWN () BLACK () OTHER _____

I HAVE HAD: () ENDOMETRIOSIS () CONSTIPATION WITH PERIODS () DIARRHEA WITH PERIODS

ORGAN DROP: () UTERUS IN POSITION () UTERUS OUT OF POSITION () BLADDER PROLAPSED

I AM/HAVE BEEN: () ON BIRTH CONTROL PILL _____ () TOTAL YEARS ON BCP ____
() MENOPAUSE AT AGE _____ () HYSTERECTOMY AT AGE _____

I AM ON HORMONE () ESTROGEN () PROGESTIN () ORAL () PATCH
REPLACEMENT: () WILD YAM CREAM () BIOIDENTICAL FORMULA

I HAVE BREAST SORENESS: () BEFORE PERIOD () DURING PERIOD () AFTER PERIOD () ALL MONTH () NOT AT ALL
I HAVE: () FIBROCYSTIC BREASTS () HAD BREAST CANCER () PRODUCE MILK BUT NOT PREGNANT OR NURSING

MY BREASTS ARE: () FIRM () SOFT AND SAGGY () HAVE IMPLANTS () HAD REDUCTION SURGERY

I: () HAVE CHILDREN () BEEN PREGNANT ____ TIMES () LIKE CHILDREN () DISLIKE CHILDREN
() WANT MORE () DON'T WANT MORE () AM STERILE () FEAR PREGNANCY

I GET: () BLADDER INFECTIONS () YEAST INFECTIONS () YEAST INFECTIONS AFTER ANTIBIOTICS
() VAGINAL ITCHING/BURNING ON () INSIDE () OUTSIDE
() VAGINAL DRYNESS () PAINFUL INTERCOURSE

I URINATE: () ____ TIMES PER DAY () ____ TIMES AT NIGHT () MORE FREQUENTLY THAN NORMAL
() WITH PAIN () WITH DIFFICULTY STARTING/STOPPING () WITH ITCHING OR BURNING

MY URINE COLOR IS: () PALE YELLOW () BRIGHT YELLOW () DARK YELLOW () OTHER _____
MY URINE IS: () CLEAR () CLOUDY () WITH MUCUS IN IT () VARIES A LOT
MY URINE HAS: () ODOR DESCRIBE _____

I HAVE/HAD: () VENEREAL DISEASE () GENITAL HERPES () HERPES I () HIV/AIDS

MY LIBIDO IS: () NORMAL () EXCESSIVE () INCREASED () DECREASED () ABSENT

ARE YOU CURRENTLY SEEING ANY OTHER HEALTHCARE PROFESSIONAL SUCH AS A DENTIST, MASSAGE THERAPIST, ACUPUNCTURIST, PSYCHOLOGIST, ETC? PLEASE EXPLAIN:

PLEASE FILL OUT YOUR FAMILY HEALTH HISTORY ON THE CHART BELOW. PUT AN "N" IN THE BOX IF THEY HAVE IT NOW OR A "P" IF THEY HAD IT IN THE PAST.

	ALCOHOLISM	ALLERGIES	ALZHEIMER'S DISEASE	ARTHRITIS	ATHEROSCLEROSIS	CANCER	DIABETES	EPLILEPSY	GLAUCOMA	HEADACHES	HIGH BLOOD PRESSURE	KIDNEY DISEASE	OBESITY	OSTEOPOROSIS	SINUS PROBLEMS	STROKE	THYROID PROBLEM	ULCERS
You																		
Spouse																		
Children																		
Mother																		
Father																		
Maternal grandparents																		
Paternal grandparents																		
Sisters																		
Brothers																		

Use this space to add anything else you would like to share about your health concerns or that you think the doctor should know:

Please review this form to be sure your answers are accurate and sign below.
Thank you for choosing our clinic. We look forward to working with you on your health goals.

Signature _____

Date _____