**First Consultation Questionnaire Form**

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| **Name:** | | **Date of birth:** |
| **What is your main reason for seeking treatment?** | | |
| **Major Symptoms:** Please list in order of importance what symptoms concern you and for how long has this problem been going on? | | |
| **To what extent do these conditions interfere with your daily activities (work, sleep, socializing, etc.)?** | | |
| **Have you had other forms of treatment for this condition previously? If yes, what was it and how successful have they been?** | | |
| **Previous illness：** | | |
| **Surgical history:** | | |
| **Allergy reaction:** | **How was your general health as a child?** | |
| **Medication or supplements:** | | |
| **Please describe your pain**   |  |  |  |  | | --- | --- | --- | --- | | Constant ( ) | Comes & Goes ( ) | Fixed ( ) | Moves ( ) | | Unilateral ( ) | Dull ( ) | Sharp ( ) | Burning ( ) |   Better:   |  |  |  | | --- | --- | --- | | Heat ( ) | Cold ( ) | Motion ( ) | | Rest ( ) | Pressure ( ) | When: am or pm |   **Worse:**   |  |  |  | | --- | --- | --- | | Heat ( ) | Cold ( ) | Motion ( ) | | Rest ( ) | Pressure ( ) | When: am or pm |   **Pain level: (0-better to 10-worse)**  **Pain Scale: 0 1 2 3 4 5 6 7 8 9 10**  **Function Scale: 0 1 2 3 4 5 6 7 8 9 10** | | image10**Circle for pain** |

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| **Do you have:** | | | | | | | | | | |
| Heart Disease/ Pacemaker |  | Kidney disease |  | Infection disease (HIV) |  | Haemophilia | Epilepsy 0r Seizures | |  | |
| Thrombosis (blood clots) |  | Diabetes |  | Hepatitis A B or C |  | Surgical Replacements | Fear of Needles | |  | |
| Bleeding disorder |  | Cancer |  | Tuberculosis |  | Implants | Others: | |  | |
| **Family history (Mother, Father, Siblings, Grandmother, Grandfather)** | | | | | | | | | | |
| Alcoholism |  | Bleeding disorder |  | Diabetes |  | Kidney Disease |  | Stroke | |  |
| Allergies |  | Cancer |  | Heart Disease |  | Mental illness |  | Other: | | |
| Asthma |  | Depression |  | High Blood Pressure |  | Seizures |  |

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| **For Men** |
| Do you have any bothersome urinary symptoms? YES NO  If yes, please describe: |
| Do you have the following signs / symptoms?   |  |  |  | | --- | --- | --- | | Frequent need to urinate at night | Pain of testicles | Premature ejaculation | | Impotence/ erectile dysfunction | Pain or swelling of the testicles | Feeling of coldness or numbness in genitalia | |

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| **For Women** | | | | | |
| Are you pregnant now? YES NO UNSURE | | Age: First period \_\_\_\_\_\_\_\_\_ | | | Menopause (if applicable) \_\_\_\_\_\_\_\_\_ |
| How many Live Births: | Miscarriages: | | | Abortions: |  |
| Have you been through IVF? | | Do you have any gynecological issues? | | | |
| Date: Last pap smear | | Last mammogram | | | |
| Any history of an abnormal pap smear? YES NO | | It’s your menstruation regular? | | | |
| How many days of your menstrual cycle? | | Average number of days of flow? | | | |
| How many days of your period last? The | | | Flow is: NORMAL HEAVY LIGHT | | |
| The color is: NORMAL DARK PURPLE LIGHT BROWN BROWN | | | | | |
| Do you have the following menstruation related signs/symptoms?   |  |  |  |  | | --- | --- | --- | --- | | PMS | Cramps or dull pain | Breast distention | Blood clots | | Lower abdominal pain | Lower back pain with cold sensation | Cold intolerance | Nausea or vomiting | | Bloating or constipation | Epigastric distending pain | Fatigue | Irritable and restless | | Mood swings | Headache or migrants | Vaginal discharge | Bleeding between periods | | | | | | |
| Do you get up at night to urinate? YES NO | | If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| **Which conditions do you have now (N) or had in the past (P)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | N | | P | | |  | | | | | | | N | | P | | |  | | | | | N | | | P | | | |  | | N | | P | | | |  | | | | N | |
| Anemia |  | |  | | | Cataracts | | | | | | |  | |  | | | Gout | | | | |  | | |  | | | | Meningitis | |  | |  | | | | Stroke | | | |  | |
| Appendicitis |  | |  | | | Celiac Disease | | | | | | |  | |  | | | Heart Disease | | | | |  | | |  | | | | Mononucleosis | |  | |  | | | | Stomach Disorder | | | |  | |
| Arteriosclerosis |  | |  | | | Chicken Pox | | | | | | |  | |  | | | Prostate Disorder | | | | |  | | |  | | | | Multiple Sclerosis | |  | |  | | | | Thyroid Disorder | | | |  | |
| Arthritis |  | |  | | | Chronic Fatigue | | | | | | |  | |  | | | Herpes | | | | |  | | |  | | | | Mumps | |  | |  | | | | Tonsillitis | | | |  | |
| Bladder Disease |  | |  | | | Chronic Pain | | | | | | |  | |  | | | High Cholesterol | | | | |  | | |  | | | | Osteoarthritis | |  | |  | | | | Tuberculosis | | | |  | |
| Blood Disorder |  | |  | | | Diabetes I | | | | | | |  | |  | | | Intestinal Disorder | | | | |  | | |  | | | | Osteoporosis | |  | |  | | | | Ulcers | | | |  | |
| Bronchitis |  | |  | | | Diabetes II | | | | | | |  | |  | | | Impotence | | | | |  | | |  | | | | Parkinson’s | |  | |  | | | | Other: | | | |  | |
| Broken Bones |  | |  | | | Emphysema | | | | | | |  | |  | | | Kidney Disease | | | | |  | | |  | | | | Pneumonia | |  | |  | | | |  | |
| Bulimia |  | |  | | | Epilepsy | | | | | | |  | |  | | | Liver Disease | | | | |  | | |  | | | | Polio | |  | |  | | | |  | |
| Cancer |  | |  | | | Measles | | | | | | |  | |  | | | Lupus | | | | |  | | |  | | | | Hernia | |  | |  | | | |  | |
| Candidiasis |  | |  | | | Goitre | | | | | | |  | |  | | | Lyme Disease | | | | |  | | |  | | | | Scarlet Fever | |  | |  | | | |  | |
| **Please check all the conditions that apply to your health history**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **General:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Low energy level | | | | | | | | |  | | Excessively thirsty | | | | | | | | | |  | Sweaty palms / feet | | | | | | | | | | |  | | | | Weight loss | | | | | |  | | |
| Spontaneous sweating | | | | | | | | |  | | Chills / Fever | | | | | | | | | |  | Hot flashes | | | | | | | | | | |  | | | | Weight gain | | | | | |  | | |
| Feel too hot | | | | | | | | |  | | Avoid heat or cold | | | | | | | | | |  | Night sweats | | | | | | | | | | |  | | | | Other: | | | | | |  | | |
| Feel too cold | | | | | | | | |  | | Cold hands / feet | | | | | | | | | |  | Lack of sweating | | | | | | | | | | |  | | | |
| **Do you experience any of these emotions?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anger | |  | | Depression | | | | | | | |  | | | | Impatience | | | | | | | |  | | | Frustration | | | | | | | |  | | | | Worry | | | |  | | |
| Anxiety | |  | | Stress / Tension | | | | | | | |  | | | | Impulsiveness | | | | | | | |  | | | Mood Swings | | | | | | | |  | | | | Sadness | | | |  | | |
| Bitterness | |  | | Fear | | | | | | | |  | | | | Irritability | | | | | | | |  | | | Over excitement | | | | | | | |  | | | | Grief | | | |  | | |
| **Emotional / Psychological / Mental:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Trouble falling asleep | | | | |  | | | Poor memory | | | | | |  | | | Cry uncontrollably | | | | | | | |  | | | Worry a lot | | | | |  | | | Mentally restless | | | | | | | |  | |
| Trouble staying asleep | | | | |  | | | Trouble concentrating | | | | | |  | | | History of abuse | | | | | | | |  | | | Poor coordination | | | | |  | | | Vivid / disturbing dreams | | | | | | | |  | |
| **Skin and nails:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rashes | | | | | | |  | | | Bruise easily | | | | | | | | |  | Boils | | | | | | | | |  | | Weak or brittle nails | | | | | | | | |  | Acne | | | |  |
| Itching | | | | | | |  | | | Slow wound healing | | | | | | | | |  | Hives | | | | | | | | |  | | Pitted nails | | | | | | | | |  | Eczema | | | |  |
| Colour change of skin | | | | | | |  | | | Skin infections | | | | | | | | |  | Hair falling out | | | | | | | | |  | | Grooves in nails | | | | | | | | |  | Herpes | | | |  |
| Psoriasis | | | | | | |  | | |

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| **Head, Eyes, Ears, Nose, Throat:** | | | | | | | | | |
| Headaches |  | Ringing in ears |  | Contacts or glasses |  | Nasal obstruction |  | Mouth ulcers / sores |  |
| Migraines (triggers) |  | Dizziness |  | Tearing of eye |  | Runny nose |  | Bad breath |  |
| Jaw pain/ TMJ |  | Spots in vision |  | Dry or burning eye |  | Sneezing |  | Bleeding gums |  |
| Impaired hearing |  | Poor night vision |  | Itchy eye |  | Nose bleeds |  | Dry mouth |  |
| Hearing loss |  | Double / blurred vision |  | Red or inflamed eye |  | Loss of smell |  | Recurrent sore throat |  |
| Ear aches |  | Eye pain / strain |  | Sinus problems |  | Teeth problems |  | Conjunctivitis |  |
| Any head injury |  | | | | | | | | |

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| **Respiratory:** | | | | | | | |
| Cough / Wheezing |  | Frequent colds / flus |  | Coughing up blood |  | Recurrent sinus infections |  |
| Production of phlegm |  | Shortness of breath |  | Pulmonary hypertension |  | Chronic allergies |  |
| Asthma |  | Cystic fibrosis |  | Lung cancer |  | Others |  |

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| **Cardiovascular:** | | | | | | | | | | | | | | | | | |
| Chest pain |  | | Low blood pressure | | |  | | Palpitations |  | | Poor circulation | |  | | Fainting spells | |  |
| High blood pressure |  | | High cholesterol | | |  | | Heart racing |  | | Irregular heartbeat | |  | | Blood clots / Thrombosis | |  |
| Acute thread veins |  | |
| **Digestive:**   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Nausea |  | Excessive hunger |  | Indigestion |  | Stomach ulcer |  | Abdominal pain |  | | Vomiting |  | Hypoglycaemia |  | Bloating after meals |  | Gas |  | Stomach ache |  | | Low appetite |  | Hyperglycaemia |  | Reflux or heartburn |  | Diarrhea / Loose stool |  | Constipation / Hard stool |  | | Fatigue after meals |  | Jaundice |  | Haemorrhoids |  | Blood in stool |  | Eating disorder |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Urinary tract:** |  |  |  |  |  |  |  | | Frequent urination |  | Burning / pain on urinating |  | Cloudy urine |  | Frequent UTI’s |  | | Frequent night urination |  | Very pale urine |  | Scanty urine |  | Blood in urine |  | | Poor bladder control |  | Dark urine |  | Profuse urine |  | Kidney or bladder stones |  |   **Musculoskeletal:** | | | | | | | | | | | | | | | | | |
| Joints | |  | | Hips |  | | Neck | | |  | | Abdomen | |  | | Joint stiffness |  |
| Arms | |  | | Legs |  | | Shoulders | | |  | | Lower abdomen | |  | | Broken bones |  |
| Hands | |  | | Feet |  | | Upper back | | |  | | Lower back | |  | | Knees |  |
| Spinal problems | |  | | Wrists |  | | Ankles | | |  | | Elbows | |  | | Other: | |

**Life style**

|  |  |  |
| --- | --- | --- |
| Smoking  Yes No  If yes, how many per day? | Alcohol  Yes No  If yes, how many per day? | Rec Drugs  Yes No  If yes, how often? |

Consumption per day of?

Water: \_\_\_\_\_\_ Coffee: \_\_\_\_\_\_ Tea: \_\_\_\_\_\_ Soda: \_\_\_\_\_\_ Any addiction? \_\_\_\_\_\_

**Are you?** Always thirsty Never Thirsty for sips later in the day

Do you prefer: Cold drinks Warm drinks or both

**Do you DISLIKE:** Cold Wind Dampness Heat Loud Noises Crowds

**What are your typical eating habits?**

|  |  |  |  |
| --- | --- | --- | --- |
| Skip breakfast | Eat in a rush | Eat when not hungry | Eat too fast |
| Eat late at night | Cannot eat when worried/stress | Excess hunger | No desire to eat |

Stress full level ：

What do you do to release your stress:

What kind of exercise do you normally and how often?

**Thank you for taking the time to fill out this form. This will help us assess your health and give you a better treatment. All information is confidential and will not be shared without your explicit permission.**