Innovative
Health & Longevity

HEALTH QUESTIONNAIRE

Steps for your appointment:

1) Please fill out all New Patient forms in their entirety.

2) If you have any recent labs (within 12 months), please bring them to your appointment.

3) If you are married or in a relationship, please **bring your spouse or significant other** with you to your appointment. (*There will be a lot of information covered concerning your unique condition as well as the fundamentals of the program*).

4) Please arrive on time.

5) We require a 24-hour notice to change or cancel your appointment.

Note: If these steps are not followed, it may compromise the full value of your consultation and therefore we will have to reschedule your appointment.

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Patient Introduction:

Name: _____ **Date:** _____
First Middle Last

Address:

_____
Street **City/State** **Zip**

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Birthdate: _____

Marital Status: _____

Occupation: _____

Employer: _____

Primary Physician: _____ **City:** _____

Referred to our office or seminar by:

_____

_____

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Medication List:

Name: _____ **Date of Birth:** _____

Please list ALL medications and supplements that you take. This includes prescriptions, vitamins, and over the counter medications.

MEDICATION/Supplement NAME & STRENGTH	HOW OFTEN DO YOU TAKE IT

Do you have any allergies to medications? _____**No/Unknown** _____**Yes-Please list below**

MEDICATION/Supplement NAME	REACTION TO MEDICATION/Supplement

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HEALTH QUESTIONNAIRE

Current and Past Medical Problems:

DIABETICS ONLY: Most Recent A1C: _____

Diabetes Complications: _____ Heart Disease _____ Stroke _____High Cholesterol
_____Neuropathy _____Retinopathy/Vision problems _____Amputation _____Kidney failure

Surgical History:

Main Complaints:

1. _____ 2._____

3. _____ 4. _____

How long have you suffered with these problems? _____

Would you like improvement with any of the following? (Check all that apply)

_____ **Digestion: Reflux, Gas, Constipation**
_____ **Sleep: Problems falling asleep or staying asleep**
_____ **Sense of well-being**
_____ **Energy**

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What have you tried doing in the past to resolve these problems, but they DID NOT work?

Have you become discouraged or stressed about handling these problems?

When your problems are at their worst, how does it make you feel?

How do these problems interfere with the following areas in your life?

Family:

Work:

Hobbies:

Life:

When your symptoms are at their worst, how much older do they make you feel?

Do you know how these problems may have started?

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Are you here visiting us to:

a) Resolve my immediate problem
b) Undergo a lifestyle program for optimized living
c) Both
d) Other: _____

How have you taken care of your health in the past? (circle all that apply)

Medications
Routine medical exams
Exercise
Diet & Nutrition Changes
Holistic Approach
Vitamins
Chiropractic Care
Other: _____

How did the previous methods work for you?

Please circle the aspects of your life you fear are going to be impacted if your current state of health does not improve.

Job
Kids
Marriage
Sleep
Freedom
Future abilities
Finances
Time

Are there any health conditions you are afraid your symptoms may turn into? (circle all that apply)

Disability
Weight Gain
Heart Disease
Depression
Arthritis
Cancer
Diabetes
Other: _____

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Where do you picture yourself being in the next 3-5 years if these problems are not taken care of? Please be specific.

_____

_____

_____

What would be different or better without these problems? (circle all that apply)

Stress Level
Energy Level
Self Esteem
Confidence
Sleep
Work
Outlook
Family

If we were to sit down and discuss your life 3 years from now and look back at it today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness; i.e. health, family, work, finances, travel, marriage, or bucket list items).

_____

_____

_____

_____

What potential barriers do you foresee that would prevent these things from happening?

_____

_____

_____

_____

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HEALTH QUESTIONNAIRE

Do you feel it is possible to eliminate or prevent these potential barriers?

_____

_____

_____

What are your strengths that will enable you to accomplish your goals?

_____

_____

_____

Rate on a scale of 1-10:

_____ **How important is it for you to resolve your health concerns?**

_____ **Do you feel that you are coachable and would enjoy working with a mentor?**

_____ **Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?**

How would you describe your family support:

_____ **My spouse fully supports my decision concerning a lifestyle program.**

_____ **My spouse is not really involved, but wants me to get the help I need.**

_____ **My spouse needs more information to be supportive.**

_____ **I am single, but do have a support system with friends.**

_____ **I am single and do not have a support system.**

_____

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Patient Name: _____ Date: _____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale
0-*Never or almost never* have the symptom
1-*Occasionally* have it, effect is ***not severe***
2-*Occasionally* have it, effect is ***severe***
3-*Frequently* have it, effect is ***not severe***
4-*Frequently* have it, effect is ***severe***

HEAD:

_____	Headaches	_____	Dizziness
_____	Faintness	_____	Insomnia

Total_____

EYES:

_____	Watery or itchy eyes	_____	Bags or dark circles under eyes
_____	Blurred or tunnel vision (Does not include near or far-sighted)	_____	Swollen, reddened or sticky eyelids

Total_____

EARS:

_____	Itchy ears	_____	Earaches, ear infections
_____	Drainage from ears	_____	Ringing in ears, hearing loss

Total_____

NOSE:

_____	Stuffy nose	_____	Sinus problems
_____	Hay fever	_____	Excessive mucus formation
_____	Sneezing attacks		

Total_____

MOUTH/THROAT:

_____	Chronic coughing	_____	Sore throat, hoarseness, voice loss
_____	Canker sores	_____	Gagging, frequent throat clearing
_____	Swollen or discolored tongue, gums, lips		

Total_____

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SKIN:

_____	Acne	_____	Hair loss
_____	Hives, rashes, dry skin	_____	Flushing, hot flashes
_____	Excessive sweating		

Total_____

HEART:

_____	Chest pain	_____	Irregular or skipped heartbeat
_____	Rapid or pounding heartbeat		

Total_____

LUNGS:

_____	Chest congestion	_____	Asthma, bronchitis
_____	Shortness of breath	_____	Difficulty breathing

Total_____

DIGESTIVE TRACT:

_____	Nausea, vomiting	_____	Diarrhea
_____	Constipation	_____	Bloated feeling
_____	Belching, passing gas		
_____	Heartburn	_____	Intestinal/stomach pain

Total_____

JOINTS/MUSCLE:

_____	Pain or joint aches	_____	Arthritis
_____	Stiffness or limited mobility	_____	Pain or muscle aches
_____	Feeling of weakness or tiredness		

Total_____

WEIGHT:

_____	Binge eating/drinking	_____	Craving certain foods
_____	Excessive weight	_____	Compulsive eating
_____	Water retention	_____	Underweight

Total_____

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ENERGY:

_____	Fatigue, sluggishness	_____	Apathy, lethargy
_____	Hyperactivity	_____	Restlessness

Total_____

MIND:

_____	Poor memory	_____	Slurred speech
_____	Confusion, poor comprehension	_____	Poor concentration
_____	Poor physical coordination	_____	Difficulty making decisions
_____	Stuttering or stammering	_____	Learning disabilities

Total_____

EMOTIONS:

_____	Anger, irritability, aggressiveness	_____	Depression
_____	Anxiety, fear, nervousness	_____	Mood swings

Total_____

OTHER:

_____	Frequent or urgent urination	_____	Frequent illness
_____	Genital itch or discharge		

Total_____

GRAND TOTAL_____

ear nose throat allergy hearing
integrative ENT
Compassionate Quality Care

Otolaryngology History and Review of Symptoms

Name: _____

Date: _____

Chief Complaint (What brings you in?)

_____

_____

Have you had any testing done related to your problem? MRI, CT, labs? When & Where?

_____

_____

_____

Medical Conditions: _____

_____

_____

Operations: _____

_____

_____

Occupation:

_____

Do you Smoke?: [ ] Yes [ ] No
How long: _____ Year Quit: _____
Pack / Day: _____
2nd Hand Smoke Exposure?: _____

Do You Drink?
Alcohol, how often_____
Caffeine, how often_____

Noise Exposure?: _____

Family History: Relationship?
Allergies _____
Bleeding Problems_____
Diabetes _____
Anesthesia Problems _____
Cancer_____
Thyroid_____
Heart Disease _____
Other _____
Females Only continue
Breast cancer in family?_____
Uterine, Ovarian or cervical cancer
Are you still having regular periods? ( )yes ( )no
Have you had a hysterectomy? ( )yes ( )no

Check and explain any of the following that apply

General	Fever:_____
	Excessive fatigue:_____
	Weakness:_____
	Weight Changes:_____
ENT	Headaches:_____
	Head injury:_____
	Hearing:_____
	Ringing in ears:_____
	Dizziness:_____
	Earaches / drainage:_____
	Sinus drainage:_____
	Nasal blockage:_____
	Frequent sore throat:_____
	Snoring:_____
	Hoarseness:_____
	Lump in neck:_____
	Goiter:_____
All / Immu	Susceptible to infection_____
	Itchy / watery eyes:_____
	Clear runny nose:_____
	Frequent sneezing:_____
	Food sensitivity:_____
GI	Trouble swallowing:_____
	Heartburn:_____
	Excessive belching or gas:_____
	Hepatitis:_____
	Diarrhea &/or Constipation:_____
	Bloating: _____
Respiratory	Cough:_____
	Asthma / Emphysema / TB:_____
	Coughing up blood:_____
Endocrine	Thyroid problems_____
	Heat or cold intolerance_____
	Diabetes_____
Musc/Skel	Neck pain/stiffness_____
	Neck injury/arthritis_____
Neuro	Localized weakness/numbness or paralysis_____
	Stroke_____
Eyes	Double Vision_____
	Other_____
Heme/Lym	Swollen Glands_____
	Bleeding tendency/excessive bruising_____
CV	Anesthetic problems_____
	High blood pressure_____
	Heart murmur_____
	Heart problems_____
	Circulation problems_____
Skin	Rashes/lumps/sores_____
	Change in texture of hair/nails_____
Psych	Nervousness_____
	Tension_____