

Patient Questionnaire

Patient's Name: _____ Birth Date: _____
 Age: _____ Marital Status (Circle): S M W D Gender (Circle): Male Female
 Address: _____
 City/State/Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ Email: _____
 Occupation or Year in School: _____
 Name of Work or School: _____
 Parent or Guardian Name (if child) _____



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 RESTORING HEALTH WITH
 HOLISTIC MEDICINE
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INSTRUCTIONS: Check applicable boxes or write your answer in the space provided

Allergies

Are you allergic to...	Are you allergic to...	Are you allergic to...
<input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Any other drugs—List:	<input type="checkbox"/> Any foods—List:
<input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Morphine		
<input type="checkbox"/> Other antibiotics—List:	<input type="checkbox"/> adhesive tape <input type="checkbox"/> alcohol	
	<input type="checkbox"/> iodine contrast	<input type="checkbox"/> shellfish

Please List all Supplements and Natural Medicines, Pharmaceutical Drugs, and Contraceptives You are Currently Using

Family History

	Father	Mother	Brother				Sister				Children	Father's		Mother's	
			1	2	3	4	1	2	3	4		Dad	Mom	Dad	Mom
Age (now or at death)															
Health (well/fair/poor/deceased)															
Alcoholism / Addiction															
Asthma															
Bleeding Disorder															
Cancer															
Diabetes															
Eczema/Hives															
Epilepsy/Seizures															
Glaucoma															
Autoimmune Problems															
Heart Problems															
High Blood Pressure															
Aneurysm of Aorta															
Kidney Disease															
Mental Illness															
Migraine															
Osteoporosis															
Stroke															
Sudden Cardiac Death															
Thyroid Disease															
Other:															

Personal History

Lymphatic	Sensitivity	Governing Vessel
<input type="checkbox"/> Infections – frequent <input type="checkbox"/> Ear Infections	<input type="checkbox"/> Animal dander sensitivity	<input type="checkbox"/> Brain Fog <input type="checkbox"/> Memory loss
<input type="checkbox"/> Post nasal drip – chronic	<input type="checkbox"/> Mold sensitivity	<input type="checkbox"/> Depression <input type="checkbox"/> Bipolar depression
<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Perfume sensitivity	<input type="checkbox"/> Headaches <input type="checkbox"/> Poor concentration
<input type="checkbox"/> Swollen “glands” – recurrent	<input type="checkbox"/> Pollen sensitivity	<input type="checkbox"/> Spinal Stiffness or Pain
<u>Lung</u>	<u>Large Intestine</u>	<u>Cellular Metabolism</u>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bowel habits – change in	<input type="checkbox"/> Always hungry
<input type="checkbox"/> Bronchitis <input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Low energy at specific times of day
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Slow metabolism
<input type="checkbox"/> Respiratory Infections – recurrent	<input type="checkbox"/> Gas <input type="checkbox"/> Bloating <input type="checkbox"/> BM < once daily	<input type="checkbox"/> Cancer
<input type="checkbox"/> Short of breath when lying down	<u>Small Intestine</u>	<u>Endocrine System</u>
<input type="checkbox"/> Short of breath with exertion	<input type="checkbox"/> Antibiotic use - frequent	<input type="checkbox"/> Hormone Imbalances
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Food in Stool	<input type="checkbox"/> Mood Swings <input type="checkbox"/> Sleep Apnea
	<input type="checkbox"/> Poor Diet	<input type="checkbox"/> Sleep problems <input type="checkbox"/> Snoring
	<input type="checkbox"/> Yeast Infections	<input type="checkbox"/> Heat or Cold Intolerance <input type="checkbox"/> Hair Loss

Nervous System <input type="checkbox"/> Anxiety <input type="checkbox"/> Irritability <input type="checkbox"/> Panic attacks <input type="checkbox"/> Memory problems <input type="checkbox"/> Seizures <input type="checkbox"/> Vision changes <input type="checkbox"/> Hearing loss <input type="checkbox"/> Nervousness <input type="checkbox"/> Jumpy <input type="checkbox"/> Jittery	Skin <input type="checkbox"/> Acne <input type="checkbox"/> Dryness or Cracking <input type="checkbox"/> Eczema <input type="checkbox"/> Rashes <input type="checkbox"/> Psoriasis	Urinary/Bladder <input type="checkbox"/> Bed-wetting <input type="checkbox"/> Itching <input type="checkbox"/> Infections – recurrent <input type="checkbox"/> Loss of or inability to hold urine <input type="checkbox"/> Frequent urination
<input type="checkbox"/> Tremors/hands shaking	Fatty Tissue <input type="checkbox"/> Breast Tumors <input type="checkbox"/> Degenerative Liver Disorders	<input type="checkbox"/> Pain with urination
Pancreas <input type="checkbox"/> Insulin resistance <input type="checkbox"/> Low blood sugar <input type="checkbox"/> Metabolic Syndrome X <input type="checkbox"/> Diabetes <input type="checkbox"/> Must have meals on-time	<input type="checkbox"/> Fatty Tumors or Lipomas <input type="checkbox"/> Problems burning Fat	Trauma Any <input type="checkbox"/> broken <input type="checkbox"/> cracked bones? <input type="checkbox"/> recurrent dislocations <input type="checkbox"/> knocked unconscious <input type="checkbox"/> head injury <input type="checkbox"/> poisoning <input type="checkbox"/> food <input type="checkbox"/> drug <input type="checkbox"/> chemical
Spleen <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Infections – recurrent <input type="checkbox"/> Low immune response	Gall Bladder <input type="checkbox"/> Discomfort after eating <input type="checkbox"/> Gallstones <input type="checkbox"/> Stool Floats <input type="checkbox"/> Problems losing weight	<input type="checkbox"/> sprains <input type="checkbox"/> falls on tailbone
Liver <input type="checkbox"/> Blood disorders <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Low platelet count <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Anemia <input type="checkbox"/> Discomfort in Liver Region	Ovary/Uterus (Women only) <input type="checkbox"/> Irregular periods <input type="checkbox"/> Mood swings <input type="checkbox"/> PMS <input type="checkbox"/> Pain or discomfort with menstruation	I am stressed out by: <input type="checkbox"/> work <input type="checkbox"/> financial worries or problems <input type="checkbox"/> relatives or family <input type="checkbox"/> society
Joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Back Pain	<input type="checkbox"/> Urinating more often than usual <input type="checkbox"/> Difficulty starting urine stream or slow stream <input type="checkbox"/> Prostate pain or discomfort <input type="checkbox"/> Morning erection not everyday	Overall Energy and Endurance <input type="checkbox"/> Lack motivation or drive <input type="checkbox"/> Lack stamina or endurance
<input type="checkbox"/> Discomfort with movement <input type="checkbox"/> Weather-triggered ailments	Conception Vessel <input type="checkbox"/> Infertility <input type="checkbox"/> Impotency <input type="checkbox"/> Miscarriages <input type="checkbox"/> Low Sex Drive <input type="checkbox"/> Dry Vagina	<input type="checkbox"/> Lack strength
Stomach <input type="checkbox"/> Acid problems, reflux or heartburn <input type="checkbox"/> Bloating or gas after meals <input type="checkbox"/> Nausea <input type="checkbox"/> Digestive problems <input type="checkbox"/> Hiatal hernia	<input type="checkbox"/> Fibrocystic Breasts <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Endometriosis <input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> Other Reproductive System Issues (list):	Overall Feeling of Well Being <input type="checkbox"/> Lack feeling of fulfillment - frequently <input type="checkbox"/> Lack joy and happiness - frequently <input type="checkbox"/> Lack positive outlook - frequently <input type="checkbox"/> Feel out of control - frequently
Muscles, Ligaments, Tendons <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Pain <input type="checkbox"/> Rheumatism <input type="checkbox"/> Slow recovery after exercise	Kidneys <input type="checkbox"/> Gout <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Renal insufficiency	Have you ever... <input type="checkbox"/> had counseling or psychotherapy <input type="checkbox"/> been hospitalized for psychiatric reasons <input type="checkbox"/> been prescribed psychiatric drugs <input type="checkbox"/> I pray or meditate most days
Circulation <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> Stroke or TIA <input type="checkbox"/> Cold fingers and toes <input type="checkbox"/> Bluish Skin Color <input type="checkbox"/> Reddish Skin Color <input type="checkbox"/> Skin Ulcer	<input type="checkbox"/> Gum, Jaw or Teeth Pain or Discomfort <input type="checkbox"/> Teeth Sensitivity <input type="checkbox"/> "Silver" Fillings <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Gum disease	<input type="checkbox"/> I have people I can rely on in my life
<input type="checkbox"/> Swelling of hands, feet or ankles <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Blood clots <input type="checkbox"/> Pain in legs while walking	Heart <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Failure <input type="checkbox"/> Impairments from prior infections <input type="checkbox"/> Valve problems <input type="checkbox"/> Heart Defect <input type="checkbox"/> Chest tightness <input type="checkbox"/> Chest Pressure <input type="checkbox"/> Sweating <input type="checkbox"/> Fainting or feeling faint <input type="checkbox"/> Dizziness <input type="checkbox"/> Murmur <input type="checkbox"/> Palpitations <input type="checkbox"/> Arrhythmia	Immune System Function <input type="checkbox"/> Allergies <input type="checkbox"/> Chemical sensitivities <input type="checkbox"/> Work or Live in a "Sick Building" <input type="checkbox"/> Infections – frequent <input type="checkbox"/> Were you breast fed as a baby?
Please list any other diseases or conditions:		
Surgery		
Have you had removed... <input type="checkbox"/> Tonsils <input type="checkbox"/> Appendix <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Uterus <input type="checkbox"/> Right ovary <input type="checkbox"/> Left ovary	Have you ever had a transfusion of... <input type="checkbox"/> Blood <input type="checkbox"/> Plasma Have you... <input type="checkbox"/> had a hernia repaired <input type="checkbox"/> had any other operations Explain:	Have you... <input type="checkbox"/> been hospitalized for any illness Explain:

Health Maintenance		
Have you had...	Have you had...	Have you had...
<input type="checkbox"/> Complete childhood immunizations	<input type="checkbox"/> Rhogam injection	<input type="checkbox"/> Cholesterol screening
If not, age they were stopped:	<input type="checkbox"/> any other vaccines? List:	<input type="checkbox"/> Thyroid hormone screening
<input type="checkbox"/> a flu shot (ever) Year:		<input type="checkbox"/> Rectal exam
<input type="checkbox"/> a tetanus shot within last 10 years		<input type="checkbox"/> Colonoscopy/Flexible Sigmoidoscopy

Habits		
Do you...	Do you...	Have you ever used...
<input type="checkbox"/> Exercise adequately	<input type="checkbox"/> Have sex <input type="checkbox"/> entirely satisfactory	<input type="checkbox"/> Recreational drugs
How?	<input type="checkbox"/> With men	<input type="checkbox"/> Alcohol (drinks per week)
	<input type="checkbox"/> with women	<input type="checkbox"/> Tobacco (packs per day for yrs)
<input type="checkbox"/> Awaken rested	<input type="checkbox"/> Use contraception ("protection")	<input type="checkbox"/> Antacids
<input type="checkbox"/> Sleep well	<input type="checkbox"/> Like your work (hours per day)	<input type="checkbox"/> Diet aids
<input type="checkbox"/> Average at least 8 hours sleep nightly	<input type="checkbox"/> Work indoors <input type="checkbox"/> Work outdoors	<input type="checkbox"/> Laxatives
<input type="checkbox"/> Use computer hours per day	<input type="checkbox"/> Watch TV hours per day	<input type="checkbox"/> Hormones

For Women Only		
Menstruation History		Pregnancies...
Age at onset:	<input type="checkbox"/> cramps <input type="checkbox"/> pain with period	Number of pregnancies:
Usual duration of period days	<input type="checkbox"/> hot flashes	Number of children born alive:
Cycle length <input type="checkbox"/> < 25 <input type="checkbox"/> 25 – 32 <input type="checkbox"/> > 32	<input type="checkbox"/> using or past use of birth control pills ("the Pill")	Number of premature births:
First day of last period:	<input type="checkbox"/> abnormal pap smear	Number of miscarriages:
Flow is <input type="checkbox"/> heavy <input type="checkbox"/> medium <input type="checkbox"/> light	Year of last pap smear	Number of abortions:
<input type="checkbox"/> tension <input type="checkbox"/> depression before period	Year of last mammogram:	Any Complications? Explain:

Cardiovascular Risk Assessments		
<input type="checkbox"/> I am a man over 45 years old	<input type="checkbox"/> My father, brother or son had heart disease before age 45 – OR – my mother, sister or daughter had heart disease before age 55	<input type="checkbox"/> I currently smoke
<input type="checkbox"/> I am a woman over 55 years old		<input type="checkbox"/> My good cholesterol is less than 40 mg/dl

Please go to Make an Appointment page of bethanyklug.com to calculate your Framingham Risk Score. Enter result here:

Weight History	
Weight in Pounds	400 _____
	375 _____
	350 _____
	325 _____
	300 _____
	275 _____
	250 _____
	225 _____
	200 _____
	175 _____
	150 _____
	125 _____
	100 _____
	75 _____
	50 _____
	25 _____
	0 _____
	15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95

Note **M** for marriage, **P** for pregnancy and **D** for major diet

Physical Activity Questionnaire		
In the average week , how often do you intentionally participate in the following activities. Use ½ or ¼ points if necessary.		
Give 1 point for every 15 minutes spent	Give 1 point for every 15 – 20 minutes spent	Give 1 point for every 30 minutes spent
___ Stair walking	___ Playing basketball	___ Water aerobics
___ Running 1.5 miles	___ Playing wheelchair basketball	___ Walking 2 miles (15-minute mile)
___ Jumping Rope	___ Swimming laps	___ Pushing a stroller 1.5 miles
___ Bicycling 4 miles		___ Dancing fast (social)
	Give 1 point for every 30 – 40 minutes spent	___ Bicycling 5 miles
Give 1 point for every 45 – 60 minutes spent	___ Wheeling self in wheel chair	___ Shooting baskets
___ Washing windows or floors	___ Gardening or or mowing (standing)	
___ Washing and waxing a car or boat	___ Playing touch football	TOTAL POINTS: _____
___ Vigorous Yoga	___ Playing volley ball	

Diet History

Favorite Food: Coffee Soda Pop Tea
Favorite Snack Food: Milk Yoghurt Cheese
Favorite Vegetable Margarine, Earth Balance
Number of Vegetable Servings Eaten Daily: Energy Drinks
Type of Bread Eaten Most Regularly:
Typical Breakfast
Typical Lunch:
Typical Dinner:
Amount of Cow's Milk Consumed Daily:
Oil Used for Cooking and or Salads:
List any food cravings:
Comments or additional explanation:

Other

Are you under a physician's care for any reason not noted on this form? If so, please describe. _____
What is your main reason for seeing us? _____
Is there any thing else you want us to know? _____

Completed by: _____ Date: _____
B.S. Klug (Signature) _____ Date: _____