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New Patient Questionnaire

Full Name:

Today's Date:

Street Address:

City:

State:

Zip Code:

Home Phone:

Cell Phone:

Email Address:

Age:

Date of Birth:

Height:

Weight:

Marital Status:

Name of Current/Previous Health Care Provider:

Date of Last Physical Examination:

How did you hear about LiveWell Natural Health?

Primary Concern

What is the Primary Health Concern that Brings You to See Me Today?

Brief History of Primary Concern: *(when did it start, what makes it better or worse, etc.)*

Your Top Three Health Concerns that You would like to Address:

- 1.
- 2.
- 3.

Your Personal Health History

List All Your Known Medical Problems:

List All of Your Previous Hospitalizations and Surgeries: *(year, reason, and outcome)*

List All the Prescription Drugs, Over-the-Counter Drugs, Vitamins, and Supplements that You Currently Take:

Name of Item	Strength / Dose	Frequency Taken

List all Your Known Food and Drug Allergies: *(item and the reactions you had)*

WOMEN ONLY

At What Age was Your Onset of Menstruation?

When was Your Last Period?

Are any of Your Periods Ever Heavy, Irregular, Spotting, Painful, or Contain Discharge? *(if yes, please explain)*

Do You Suffer from PMS? If Yes, Please Describe.

Number of Pregnancies:

Number of Live Births:

When was Your Last Pregnancy?

Are You Pregnant Now?

Are You Currently Breast Feeding?

Have You ever had a Cesarean, D&C, or a Hysterectomy?

In the Last Year, have You had Any Bladder, Urinary Tract, or Kidney Infections?

Any Problems with Urination Control?

Do You ever have Hot Flashes or Sweating at Night?

When was Your Last Pap Test?

When was Your Last Mammogram?

Have You Experienced Any Recent Breast Tenderness, Lumps, or Nipple Discharge?

Any Other Hormonal or Female Concerns.

HEALTH & LIFESTYLE

Describe Your Exercise Activities: *(type of activity, frequency, and intensity)*

Describe Your Interests, Hobbies, Spiritual Activities, & Things You do to Relax:

How Much Time do You Spend on a Computer per Day?

How Much Time do You Spend Watching Television per Day?

How Much Time do You Spend on Other Electronic Gadgets per Day?

Are You Currently on a Diet?

If Yes, Was the Diet Prescribed by a Physician?

Number of Meals You Eat in an Average Day:

What have You Eaten in the Past 24 Hours?

Do You Want or Need to Lose Weight? If Yes, Please Describe What You have Tried in the Past.

Do You Drink Coffee? *(if yes, number of cups per day)*

Do You Drink Caffeinated Tea? *(if yes, number of cups per day)*

Do You Drink Soda? *(if yes, number of cans per day)*

Do You Drink Alcoholic Beverages? *(if yes, number of drinks per week and the types of beverages)*

Are You Concerned About Your Alcoholic Beverage Consumption?

Not Applicable

No

Yes

Do You Use Tobacco Products? *(if yes, types of product, and usage per day)*

SLEEP

How Many Hours per Night do You Sleep?

What is the Quality of Your Sleep?

Do You have Trouble Falling Asleep?

Do You have Trouble Staying Asleep?

Do You Wake Feeling Rested?

Any Other Sleep Concerns?

Family History

Indicate Below Which of the Following Diseases that have Affected Your Relatives:

Alcoholism	Asthma	Heart Disease	Thyroid Disorder
Allergies	Cancer	Hypertension	Tuberculosis
Alzheimer's	Depression	Kidney Disease	
Anxiety	Diabetes	Liver Disease	
Arthritis	Hay Fever	Mental Illness	

RELATIVE	AGE If ALIVE	AGE AT DEATH	ALIMENTS
Mother			
Father			
Sisters			
Brothers			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts & Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts & Uncles			

SYSTEMS SURVEY FORM
(Restricted to Professional Use)

PATIENT _____ DOCTOR _____ DATE _____

AGE _____ PHONE (_____) _____ VEGETARIAN ___ Yes ___ No

INSTRUCTIONS: Circle the number that applies to you. If symptom doesn't apply, leave blank. Use (1) for **MILD** symptoms (occurs once or twice a month), (2) for **MODERATE** symptoms (occurs several times a month), and (3) for **SEVERE** symptoms (you are aware of it almost constantly).

GROUP ONE

- | | | |
|-----------------------------------|--|-----------------------------------|
| 1 - 1 2 3 Acid foods upset | 8 - 1 2 3 Gag easily | 15 - 1 2 3 Appetite reduced |
| 2 - 1 2 3 Get chilled, often | 9 - 1 2 3 Unable to relax; startles easily | 16 - 1 2 3 Cold sweats often |
| 3 - 1 2 3 "Lump" in throat | 10 - 1 2 3 Extremities cold, clammy | 17 - 1 2 3 Fever easily raised |
| 4 - 1 2 3 Dry mouth-eyes-nose | 11 - 1 2 3 Strong light irritates | 18 - 1 2 3 Neuralgia-like pains |
| 5 - 1 2 3 Pulse speeds after meal | 12 - 1 2 3 Urine amount reduced | 19 - 1 2 3 Staring, blinks little |
| 6 - 1 2 3 Keyed up - fail to calm | 13 - 1 2 3 Heart pounds after retiring | 20 - 1 2 3 Sour stomach frequent |
| 7 - 1 2 3 Cuts heal slowly | 14 - 1 2 3 "Nervous" stomach | |

GROUP TWO

- | | | |
|---|---|---|
| 21 - 1 2 3 Joint stiffness after arising | 29 - 1 2 3 Digestion rapid | 37 - 1 2 3 "Slow starter" |
| 22 - 1 2 3 Muscle-leg-toe cramps at night | 30 - 1 2 3 Vomiting frequent | 38 - 1 2 3 Get "chilled" infrequently |
| 23 - 1 2 3 "Butterfly" stomach, cramps | 31 - 1 2 3 Hoarseness frequent | 39 - 1 2 3 Perspire easily |
| 24 - 1 2 3 Eyes or nose watery | 32 - 1 2 3 Breathing irregular | 40 - 1 2 3 Circulation poor, sensitive to cold |
| 25 - 1 2 3 Eyes blink often | 33 - 1 2 3 Pulse slow; feels "irregular" | 41 - 1 2 3 Subject to colds, asthma, bronchitis |
| 26 - 1 2 3 Eyelids swollen, puffy | 34 - 1 2 3 Gagging reflex slow | |
| 27 - 1 2 3 Indigestion soon after meals | 35 - 1 2 3 Difficulty swallowing | |
| 28 - 1 2 3 Always seems hungry; feels "lightheaded" often | 36 - 1 2 3 Constipation, diarrhea alternating | |

GROUP THREE

- | | | |
|---|---|--|
| 42 - 1 2 3 Eat when nervous | 49 - 1 2 3 Heart palpitates if meals missed or delayed | 53 - 1 2 3 Crave candy or coffee in afternoons |
| 43 - 1 2 3 Excessive appetite | 50 - 1 2 3 Afternoon headaches | 54 - 1 2 3 Moods of depression - "blues" or melancholy |
| 44 - 1 2 3 Hungry between meals | 51 - 1 2 3 Overeating sweets upsets | 55 - 1 2 3 Abnormal craving for sweets or snacks |
| 45 - 1 2 3 Irritable before meals | 52 - 1 2 3 Awaken after few hours sleep - hard to get back to sleep | |
| 46 - 1 2 3 Get "shaky" if hungry | | |
| 47 - 1 2 3 Fatigue, eating relieves | | |
| 48 - 1 2 3 "Lightheaded" if meals delayed | | |

GROUP FOUR

- | | | |
|--|--|--|
| 56 - 1 2 3 Hands and feet go to sleep easily, numbness | 63 - 1 2 3 Get "drowsy" often | 68 - 1 2 3 Bruise easily, "black and blue" spots |
| 57 - 1 2 3 Sigh frequently, "air hunger" | 64 - 1 2 3 Swollen ankles worse at night | 69 - 1 2 3 Tendency to anemia |
| 58 - 1 2 3 Aware of "breathing heavily" | 65 - 1 2 3 Muscle cramps, worse during exercise; get "charley horses" | 70 - 1 2 3 "Nose bleeds" frequent |
| 59 - 1 2 3 High altitude discomfort | 66 - 1 2 3 Shortness of breath on exertion | 71 - 1 2 3 Noises in head, or "ringing in ears" |
| 60 - 1 2 3 Opens windows in closed room | 67 - 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion. | 72 - 1 2 3 Tension under the breastbone, or feeling of "tightness" worse on exertion |
| 61 - 1 2 3 Susceptible to colds and fevers | | |
| 62 - 1 2 3 Afternoon "yawner" | | |

GROUP FIVE

- | | | |
|--|---|---|
| 73 - 1 2 3 Dizziness | 82 - 1 2 3 Worrier, feels insecure | 90 - 1 2 3 History of gallbladder attacks or gallstones |
| 74 - 1 2 3 Dry Skin | 83 - 1 2 3 Feeling queasy; headache over eyes | 91 - 1 2 3 Sneezing attacks |
| 75 - 1 2 3 Burning feet | 84 - 1 2 3 Greasy foods upset | 92 - 1 2 3 Dreaming, nightmare type bad dreams |
| 76 - 1 2 3 Blurred vision | 85 - 1 2 3 Stools light-colored | 93 - 1 2 3 Bad breath (halitosis) |
| 77 - 1 2 3 Itching skin and feet | 86 - 1 2 3 Skin peels on foot soles | 94 - 1 2 3 Milk products cause distress |
| 78 - 1 2 3 Excessive falling hair | 87 - 1 2 3 Pain between shoulder blades | 95 - 1 2 3 Sensitive to hot weather |
| 79 - 1 2 3 Frequent skin rashes | 88 - 1 2 3 Use laxatives | 96 - 1 2 3 Burning or itching anus |
| 80 - 1 2 3 Bitter, metallic taste in mouth in mornings | 89 - 1 2 3 Stools alternate from soft to watery | 97 - 1 2 3 Crave sweets |
| 81 - 1 2 3 Bowel movements painful or difficult | | |

GROUP SIX

- | | | |
|---|---|---|
| 98 - 1 2 3 Loss of taste for meat | 101 - 1 2 3 Coated tongue | 104 - 1 2 3 Mucous colitis or "irritable bowel" |
| 99 - 1 2 3 Lower bowel gas several hours after eating | 102 - 1 2 3 Pass large amounts of foul-smelling gas | 105 - 1 2 3 Gas shortly after eating |
| 100 - 1 2 3 Burning stomach sensations, eating relieves | 103 - 1 2 3 Indigestion ½- 1 hour after eating; may be up to 3-4 hrs. | 106 - 1 2 3 Stomach "bloating" after eating |

GROUP SEVEN

- | | | |
|---|---|---|
| <p>(A)</p> <p>107 - 1 2 3 Insomnia</p> <p>108 - 1 2 3 Nervousness</p> <p>109 - 1 2 3 Can't gain weight</p> <p>110 - 1 2 3 Intolerance to heat</p> <p>111 - 1 2 3 Highly emotional</p> <p>112 - 1 2 3 Flush easily</p> <p>113 - 1 2 3 Night sweats</p> <p>114 - 1 2 3 Thin, moist skin</p> <p>115 - 1 2 3 Inward trembling</p> <p>116 - 1 2 3 Heart palpitates</p> <p>117 - 1 2 3 Increased appetite without weight gain</p> <p>118 - 1 2 3 Pulse fast at rest</p> <p>119 - 1 2 3 Eyelids and face twitch</p> <p>120 - 1 2 3 Irritable and restless</p> <p>121 - 1 2 3 Can't work under pressure</p> | <p>(C)</p> <p>137 - 1 2 3 Failing memory</p> <p>138 - 1 2 3 Low blood pressure</p> <p>139 - 1 2 3 Increased sex drive</p> <p>140 - 1 2 3 Headaches, "splitting or rending" type</p> <p>141 - 1 2 3 Decreased sugar tolerance</p> | <p>(E)</p> <p>150 - 1 2 3 Dizziness</p> <p>151 - 1 2 3 Headaches</p> <p>152 - 1 2 3 Hot flashes</p> <p>153 - 1 2 3 Increased blood pressure</p> <p>154 - 1 2 3 Hair growth on face or body (female)</p> <p>155 - 1 2 3 Sugar in urine (not diabetes)</p> <p>156 - 1 2 3 Masculine tendencies (female)</p> |
| <p>(B)</p> <p>122 - 1 2 3 Increase in weight</p> <p>123 - 1 2 3 Decrease in appetite</p> <p>124 - 1 2 3 Fatigue easily</p> <p>125 - 1 2 3 Ringing in ears</p> <p>126 - 1 2 3 Sleepy during day</p> <p>127 - 1 2 3 Sensitive to cold</p> <p>128 - 1 2 3 Dry or scaly skin</p> <p>129 - 1 2 3 Constipation</p> <p>130 - 1 2 3 Mental sluggishness</p> <p>131 - 1 2 3 Hair coarse, falls out</p> <p>132 - 1 2 3 Headaches upon arising wear off during day</p> <p>133 - 1 2 3 Slow pulse, below 65</p> <p>134 - 1 2 3 Frequency of urination</p> <p>135 - 1 2 3 Impaired hearing</p> <p>136 - 1 2 3 Reduced initiative</p> | <p>(D)</p> <p>142 - 1 2 3 Abnormal thirst</p> <p>143 - 1 2 3 Bloating of abdomen</p> <p>144 - 1 2 3 Weight gain around hips or waist</p> <p>145 - 1 2 3 Sex drive reduced or lacking</p> <p>146 - 1 2 3 Tendency to ulcers, colitis</p> <p>147 - 1 2 3 Increased sugar tolerance</p> <p>148 - 1 2 3 Women: menstrual disorders</p> <p>149 - 1 2 3 Young girls: lack of menstrual function</p> | <p>(F)</p> <p>157 - 1 2 3 Weakness, dizziness</p> <p>158 - 1 2 3 Chronic fatigue</p> <p>159 - 1 2 3 Low blood pressure</p> <p>160 - 1 2 3 Nails weak, ridged</p> <p>161 - 1 2 3 Tendency to hives</p> <p>162 - 1 2 3 Arthritic tendencies</p> <p>163 - 1 2 3 Perspiration increase</p> <p>164 - 1 2 3 Bowel disorders</p> <p>165 - 1 2 3 Poor circulation</p> <p>166 - 1 2 3 Swollen ankles</p> <p>167 - 1 2 3 Crave salt</p> <p>168 - 1 2 3 Brown spots or bronzing of skin</p> <p>169 - 1 2 3 Allergies - tendency to asthma</p> <p>170 - 1 2 3 Weakness after colds, influenza</p> <p>171 - 1 2 3 Exhaustion - muscular and nervous</p> <p>172 - 1 2 3 Respiratory disorders</p> |

GROUP EIGHT	FEMALE ONLY	MALE ONLY
173 - 1 2 3 Apprehension	200 - 1 2 3 Very easily fatigued	213 - 1 2 3 Prostate trouble
174 - 1 2 3 Irritability	201 - 1 2 3 Premenstrual tension	214 - 1 2 3 Urination difficult or dribbling
175 - 1 2 3 Morbid fears	202 - 1 2 3 Painful menses	215 - 1 2 3 Night urination frequent
176 - 1 2 3 Never seems to get well	203 - 1 2 3 Depressed feelings	216 - 1 2 3 Depression
177 - 1 2 3 Forgetfulness	204 - 1 2 3 Menstruation excessive and prolonged	217 - 1 2 3 Pain on inside of legs or heels
178 - 1 2 3 Indigestion	205 - 1 2 3 Painful breasts	218 - 1 2 3 Feeling of incomplete bowel evacuation
179 - 1 2 3 Poor appetite	206 - 1 2 3 Menstruate too frequently	219 - 1 2 3 Lack of energy
180 - 1 2 3 Craving for sweets	207 - 1 2 3 Vaginal discharge	220 - 1 2 3 Migrating aches and pains
181 - 1 2 3 Muscular soreness	208 - 1 2 3 Hysterectomy/ovaries removed	221 - 1 2 3 Tire too easily
182 - 1 2 3 Depression; feelings of dread	209 - 1 2 3 Menopausal hot flashes	222 - 1 2 3 Avoids activity
183 - 1 2 3 Noise sensitivity	210 - 1 2 3 Menses scanty or missed	223 - 1 2 3 Leg nervousness at night
184 - 1 2 3 Acoustic hallucinations	211 - 1 2 3 Acne, worse at menses	224 - 1 2 3 Diminished sex drive
185 - 1 2 3 Tendency to cry without reason	212 - 1 2 3 Depression of long standing	
186 - 1 2 3 Hair is coarse and/or thinning		
187 - 1 2 3 Weakness		
188 - 1 2 3 Fatigue		
189 - 1 2 3 Skin sensitive to touch		
190 - 1 2 3 Tendency toward hives		
191 - 1 2 3 Nervousness		
192 - 1 2 3 Headache		
193 - 1 2 3 Insomnia		
194 - 1 2 3 Anxiety		
195 - 1 2 3 Anorexia		
196 - 1 2 3 Inability to concentrate; confusion		
197 - 1 2 3 Frequent stuffy nose; sinus infections		
198 - 1 2 3 Allergy to some foods		
199 - 1 2 3 Loose joints		

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent _____ Standing _____ Pulse _____

Hema-Combistix Urine readings: pH _____ Albumin per cent _____ Glucose per cent _____

Occult Blood _____ pH of Saliva _____ pH of Stool specimen _____ Weight _____

Hemoglobin _____ Blood Clotting Time _____

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES

Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES

The 2nd and 3rd day of flow OR any 5 days in a row.

MALES

Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

BP SIT _____

PULSE SIT _____

SALIVA PH _____

BP STAND _____

PULSE STAND _____

BLOOD TYPE _____