calgary family wellness Dr. Susan Janssens BSc, ND

Comprehensive Patient Questionaire

Part A – General Information & History

Last name:_____**First name:**_____**Initials:**_____**Age:**____

Street Address: **D.O.B(DD/MM/YY)**_____**Weight:**_____**lbs Height:**_____

_____

_____

City:_____**Province:**_____**Postal Code:**_____

Home:_(____)_____**Bus:** _(____)_____**Mobile:**_(____)_____

Email:_____

Marital Status: □**Single** □**Married** □**Divorced** □**Common Law**

First Name of Partner/Significant Other:_____

Children: □**Y** □**N** **Ages & Sex:**_____

Occupation:_____**Place of Employment:**_____

Emergency Contact:_____**Phone:**__(_____)_____

Referral: □**Self** □**Physician** □**Other:**

Physician:_____ **Phone:**__(_____)_____

Dentist:_____ **Phone:**__(_____)_____

AHC#_____

List any health professionals you currently see		Reason
Name:	**Practise:**	
Name:	**Practise:**	
Name:	**Practise:**	
Name:	**Practise:**	

Part A continued – HISTORY

Current health conditions you desire improvement in and length of time they have been a concern to you, places in order of importance:

1._____

2._____

3._____

4._____

5._____

6._____

To what extent do these areas interfere with your daily activities? (work, sleep, etc.)?

_____

_____

Have you been given a diagnosis for this problem – If so, what?

_____

_____

Family History

Check the box if there is a family history for the following health problems. If the health condition resulted in a family member death, please mark the third column with DC.

Allergies/Hay Fever	☐		
Alcoholism	☐		
Anemia	☐		
Arthritis	☐		
Asthma	☐		
Cancer	☐		
Diabetes	☐		
Digestive Illness	☐		
Epilepsy	☐		
Glaucoma	☐		
Headaches	☐		
Heart Disease	☐		

Abbreviation LEGEND
MGM : maternal Grandmother
PGM: paternal Grandfather
MGF: maternal Grandfather
PGM: paternal Grandmother
F: father
M: mother
B: brother
S: sister
Sp: spouse
C: Children
DC: deceased

High Cholesterol	□		
High Blood Pressure	□		
Kidney Disease	□		
Mental Illness	□		
Obesity	□		
Stroke	□		
Syphilis	□		
Thyroid Condition	□		
Tuberculosis	□		
Other	□		

Part A continued – HISTORY

Post Medical

Hospitalization (year, reason):

_____

_____

Surgeries (year, reason):

_____

_____

Serious Illnesses/injuries/accidents (year, reason):

_____

_____

Childhood Illnesses:

Health as a child (1:poor to 10: excellent): **If less than 8, explain**

□ Rheumatic Fever □ German Measles □ Polio □ Allergies □ Chicken Pox □ Frequent Colds/Flus
□ Mumps □ Ear Infection □ Skin Conditions (eczema, psoriasis)

Vaccinations:

Type, year, adverse reactions:

_____

_____

Allergies: (list all known)

Allergy	Items	Reaction
Drugs		
Foods		
Other		

Pets

What Kind	How Many

Medications: (prescriptions & over the counter)

Medications	Dose	How Long?	For What?

Part A continued – HISTORY

Supplements: (non-prescriptions, herbal, nutritional, any over the counter items)

Supplement	Dose	How Long?

Have you ever had a general anesthetic? □ Y □ N if yes, when?_____

Antibiotic Use? □Y □ N If yes, when?_____

Dental

To the best of your knowledge please list all dental work/treatments you have undergone. Include fillings (specify type) pulled teeth, root canals, bridges, crowns, dentures, braces, retainer/splints, accidents/injuries or any other type of dental/jaw surgery.

Date	Treatment

Describe any current dental concerns or symptoms:_____

_____

Are you aware of any grinding of your teeth or clenching your jaw? □ Y □ N

If yes, when? □ day □ night □ both

Chemicals:

Please list any current or past exposures to solvents, chemicals, cleaning agents, insecticides, herbicides, pesticides, chemical/metal vapours, and dry cleaning agents.

Item	When	How Long?	Work or Home

Travel: (list back country and third world trips)

Item	When	Illness or Trauma

Part A continued – HISTORY

Lifestyle

Enjoy work? □ Y □ N if no, why?_____

What have been your previous occupations?_____

_____

Please indicate on the line below where you feel your current balance between work and play is:

All Work ~~0~~ ~~1~~ ~~2~~ ~~3~~ ~~4~~ ~~5~~ ~~6~~ ~~7~~ ~~8~~ ~~9~~ ~~10~~ All Play

Physical Fitness

Exercise Regularly? □ Y □ N Describe your program:_____

_____

Hobbies

Please list your hobbies or recreational interests:_____

_____

Support, Stressors & Personal Growth

Do you get along with your family? □ Y □ N

Please list the stressors that affect you the most:	Please list the people/areas that support you the most
1.	1.
2.	2.
3.	3.

Do you currently follow a (religious/spiritual) belief system?_____

Do you feel supported and comfortable with this believe system?_____

Do you: □ Meditate □ Pray □ Use Visualization □ Use Relaxation Techniques □ Use other Techniques?

Describe:_____

How might you finish this statement in regards to suggestions/programs for your health……I:

□ Can follow the plans/program □ start programs then let things slide

□ prefer choosing from options □ am easily overwhelmed

How will you know when you are feeling better:_____

_____

_____

How might things look for you when you're your life is very good?:_____

_____

_____

Do you have any concerns or reservations in pursuing complementary and alternative therapies?:_____

_____

_____

Part A continued – HISTORY

Smoking:

	How Often	How Long?	Quit –When
Cigarettes			
Cigars			
Pipes			
Marijuana			

Drinking:

	How Often	How Long?	Quit –When
Liquor			
Beer			
Wine			
Coffee			
Soft Drinks			

Diet: (for each 'yes' list type, service size, frequency)

	Yes	No	
Vegetarian	□	□	If yes, what kind? □ lacto □Ovo □Lacto-ovo □Pesco □Vegan
Meat	□	□	
Fish	□	□	
Fowl	□	□	
Dairy	□	□	
Eggs	□	□	
Beans/Legumes	□	□	
Fruits	□	□	
Vegetables	□	□	
Grains/Bread/Pasta/Cereal	□	□	

Meal	Time	Food/Drink
Breakfast		

Lunch		
Dinner		
Snacks/Dessert		
Drinks	N/A	
Cravings	N/A	
Aversions	N/A	

What kind of water do you drink and how much?_____
Please mention any foods or drinks that aggravate your symptoms or that you find hard to digest:_____
_____

Part A continued – HISTORY

Diet Continued:

How long have you been following this diet?_____

Do you eat or use any of the following:

□ Margarine □ Processed/Deli Meats □Aluminum Pots/Utensils □ Lard □Sugar
□ Microwave □ Crystal/Packaged Drinks □ Candy □ Shortening □ Artificial Sweeteners □ Fried Foods

Part B Review of Symptoms

Please complete the following section as thoroughly as you can. For every question that you answer "yes" or "past" please explain your answer further on accompanying line.

Weight	
Weight 1 Year ago	
Maximum weight	
When	
Height	
Date of Last Physical	
Date of Last blood work	

Energy 1(poor) – 10 (great):_____**Does your energy vary within a day? □ Yes □ No**
If Yes, circle & label the time(s) of day you feel is/are best (B) or (W) for you:
Midnight 1 2 3 4 5 6 7 8 9 10 11 noon 1 2 3 4 5 6 7 8 9 10 11 Midnight

What makes your energy better?_____
What makes your energy worse?_____

Sleep:

	Yes	No	Explanation
Sleep Well			If no please specify
Insomnia			
Sleepy during the day?			
Wake up at night?			
Wake early in the morning?			
Restless?			
Nightmares/dreams			

Wake to use the washroom			
Wake rested?			If no, please specify
Grains/Bread/Pasta/Cereal			
Average Hours of Sleep per night			

Sweating:

	Yes	No	Past	Explanation
Night Sweats				
Perspire profusely				
Perspire very little				
Do not perspire				
Sweat with high fever				

Skin:

	Yes	No	Past	Explanation
Eczema				
Psoriasis				
Rashes				
Hives				
Inflammation				
Infection				
Growths				
Changes in hair				
Change in nails				

Head:

	Yes	No	Past	Explanation
Headaches				

Is the pain… □ Heavy □ Distending □ Prickling □ Burning □ Other

Where does it occur? □ Forehead □ Temples □ Back of Head □ Top of Head □ Eyes □ Behind Eyes

Head injury				
Dizziness or Vertigo				
Dandruff				
Dry Scalp				
Swollen Glands				
Pain or Stiffness				

Eyes:

	Yes	No	Past	Explanation
Glasses/contacts				
Impaired Vision				
Eye Pain				
Tearing or Dryness				
Red, itching, painful				
Double Vision				
Change in nails				

Ears:

	Yes	No	Past	Explanation
Hearing loss				
Impaired hearing				
Ringing				
Earache/itch				

Nose & Sinuses:

	Yes	No	Past	Explanation
Frequent colds/Year				
Nose Bleeds				
Stuffiness				
Sinus Problems				
Post Nasal Drip				

Mouth & Throat:

	Yes	No	Past	Explanation
Frequent sore throats				
Sore tongue				
Sores in mouth/ on lips				
Gum Problems/Bleeding				
Hoarseness				
Jaw Pain				
Dental Problems				

Respiratory/Chest:

	Yes	No	Past	Explanation
Cough				If yes or past □ dry □ little phlegm □ much phlegm
Wheezing				
Spitting up blood				
Difficulty Breathing				
Pain on Breathing				
Shortness of Breath				
Shortness on lying down				
Shortness at night				
Positive Tuberculosis Test				
Asthma				
Hay Fever				
Pain				If yes or past please describe □ sides □central chest □ burning □prickling □distending □dull □other:

Part B continued- Review of Symptoms

Heart:

	Yes	No	Past	Explanation
Chest Pain				If yes or past please explain

Is the pain… □ burning □ prickling □ fullness □ tightness □ distending □ dull □ other:

Heart Disease				
High Blood pressure				
Rheumatic Fever				
Swelling in legs/ankles				
Palpitations/fluttering				

Digestion/Abdomen:

	Yes	No	Past	Explanation
Stomach/Abdominal Pain				If yes or past please explain

Is the pain… □ cramping □ prickling □ fullness □ distending □ dull □ other:

Pain is relieved by: □ pressure □ hot □ cold □ bowel movement

Trouble swallowing				
Heartburn				
Change in thirst				
Do you prefer	Hot	Cold	Not thirsty	
Changes in appetite				If yes or past describe below

Describe change as…. □ Abnormal □ overeating □ under eating □ hungry yet cannot eat

Taste/feeling in mouth □ bland □ sour □ salty □ hot □ sweet □ bitter □ sticky □metallic

Nausea				
Vomiting				
Belching/gas/bloating				
Do these symptoms occur	During meals	1 hr after meals	2-3 hours after meals	
Heaviness from foods				
Liver/gall bladder disease				
Gall stones				
High cholesterol				
Diabetes				
Mononucleosis				
Ulcers				
Pain before eating				
Pain after eating				
Low blood sugar/hypoglycemia				
Irritable before meals				
Tired after eating				
Distress from fats/greasy foods (nausea, dizzy, headaches)				
Rapid weight change				
Hiccups				

Bowel Function:

Frequency of bowel movements	Times per □ day □ week
Usual Time of bowel movements	
Consistency of bowel movements	

	Yes	No	Past	Explanation
Diarrhea				
Constipation				
Alternate Diarrhea/Constipation				
Loose/broken stools				
Stool hard to pass				
Blood/mucus in stools				
Undigested food in stool				

Urinary:

	Yes	No	Past	Explanation
Pain on urination				
Burning on urination				
Increase frequency				
Frequency at night				
Change in colour				
Change in odour				
Unable to hold urine				
Incomplete urination				
Bladder infections				
Kidney stones				

Circulation:

	Yes	No	Past	Explanation
Deep leg pain				
Cold hands/feet				
Varicose veins				
Hemorrhoids				
Anemia				
Easy bleeding/bruising				

Neurological:

	Yes	No	Past	Explanation
Fainting				
Seizures				
Paralysis				
Muscle Weakness				
Memory Loss				

Sexual Function:

	Yes	No	Past	Explanation
Change in Libido				
Loss of Libido				

Infertility				
Venereal Disease				

Female Reproduction:

	Yes	No	Past	Explanation
Age menses began				
Date of last menstruation				
No. of days of menstrual flow				
Length of complete cycle				
Date and result of last PAP				
No. of pregnancies				
No. of live births				
No. of miscarriages				
No. of abortions				
Regular Breast exam (self)				
Abnormal PAPs				
Sexually Active?				
Birth Control?				
Spotting between periods				
Are cycles regular				
Pain during intercourse				
Cramps				
Abnormal vaginal discharge	Yellow	White	Thick	Strong odour
Vaginal infections				
Menstrual flow	Normal	Heavy	Light	
Colour of flow	Normal	Bright red	Dark red	Light red

PMS □ breast tenderness □ moods □ water retention □ headaches □ craving □ back ache □ acne □ bloating other:_____

Ovarian Cysts				
Uterine fibroids				
Difficulty conceiving				
Menopausal symptoms				

Male Reproduction:

	Yes	No	Past	Explanation
Impotence				
Premature Ejaculation				
Nocturnal Emissions				
Hernias				
Testicular masses				
Testicular pain				
Are you sexually active?				
Sexual difficulties?				
Any prostate problems?				
Discharge/sores				
Difficulty starting/stopping urination				

Birth Control				

Date and results of most recent rectal exam for an enlarge prostate exam.

Risk of Infection:

	Yes	No	Details
HIV			
Hepatitis B			
Hepatitis C			

Emotional:

	Yes	No	Past	Explanation
Mood swings				
Depression				
Anger/resentment				
Anxiety/nervousness				
Fear				
Helpless				
apathy				

Musculoskeletal:

	Yes	No	Past	Explanation
Joint Pain/Stiffness				
Muscle Pain/Stiffness				
Muscle Spasms/cramps				
Low back pain				
Numbness/tingling				
Arthritis				
Broken bones				

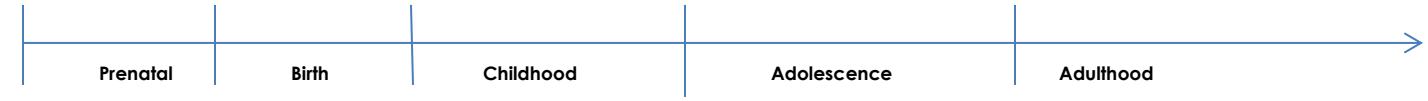
Miscellaneous:

	Yes	No	Past	Explanation
Thyroid Problems				
Heat Intolerance				
Cold intolerance				
Fever				
Chills				
Alternating Chills & Fever				
Body feels cold				
Easy weight gain				
Rapid weight change				
Dizzy upon standing				
Fluoride tooth paste				
Drink tap water				

Part C: Stressors & Symptoms

Using the timeline below, list the *stressors* (surgery, accidents/injury, change in work/residence/relationships, births, loss, mental/emotional stress etc.) and *symptoms* (pain, digestive concerns, fatigue, headaches, allergies, menstrual changes, behaviour/mood changes, etc.)

STRESSORS:



SYMTPOMS:

Part D: Neurotransmitter Questionnaire

In the Questionnaire that follows, read each statement and score it in the margin as follows:

- **0 – points if this statement is not true at or does not apply to you.**
- **1 – point if the statement is true a lot of the time and/or is affecting the quality of your life.**
- **Please respond to all questions as though you were not taking any medications or supplements.**

SECTION 1: Type- S

#	Question	Pts
1.	Do you have a tendency to be negative or have dark pessimistic thoughts?	
2.	Are you often worried or anxious?	
3.	Do you have feelings of low self-esteem and/or lack of confidence?	
4.	Are you self-critical and feel guilty of small issues?	
5.	Do you have obsessive, repetitive, angry, useless thought that you are unable to turn off? Do they happen when you are trying to fall asleep?	
6.	Can your behaviour become obsessive? This can show up as difficulty making transitions, being inflexible, a perfectionists, controlling? Computer, TV, or work addict?	
7.	Do you suffer from seasonal affective disorder? Tend to get blue in the winter months? Symptoms of this are a tendency to gain weight, fatigue, depression and sleeping problems during the winter.	
8.	Are you apt to be irritable, impatient, edgy or angry?	
9.	Are you shy or fearful? Can you be nervous or panicky about heights, flying, enclosed spaces, public performances, bugs, crowds, leaving house etc.?	
10.	Do you have anxiety or panic attacks?	
11.	Do you suffer from PMS or menopausal moodiness (tears, anger and/or depression)?	
12.	Do you dislike hot weather?	
13.	Do you find it hard to get to sleep?	
14.	Do you wake up at night, have restless or light sleep, or wake too early in the morning?	
15.	Do you find relief from the about symptoms through exercise?	
16.	Do you crave sweet or starchy snacks, wine or marijuana in the afternoons, evenings or in the middle of the night?	
17.	Do you have fibromyalgia, TMJ?	
18.	Have you had suicidal thoughts or plans?	
19.	Do you have gastrointestinal disorders such as irritable bowel syndrome, gas and/or bloating?	
20.	Do you suffer from general fatigue?	
	TOTAL	

Part D: Neurotransmitter Questionnaire

SECTION 2: Type –D

#	Question	Pts
1.	Do you feel flat and bored a lot of the time?	
2.	Do you like to sleep more than normal and are slow to get out of bed?	
3.	Do you crave or use stimulants like coffee, recreational drugs, alcohol and chocolate, diet soda, ephedra and cocaine to get high?	
4.	Do you lack libido, a reduced sex drive?	
5.	Do you feel that you have reduced feelings of satisfaction and assertiveness?	
6.	Has your short term memory, concentration and ability to learn changed for the worse?	
7.	Do you lack appetite?	
8.	Do you tend to have muscle stiffness?	
9.	Do you crave pleasurable experiences?	
10.	Have you been under a lot of stress in your life from traumatic experiences?	
11.	Do you get more accomplished under high stress environments?	
12.	Are you a procrastinator, waiting until the last minute to accomplish tasks?	
13.	Do you tend to be low on physical or mental energy?	
14.	Do you have to push yourself to exercise?	
15.	Is your drive, enthusiasm and motivation on the low side?	
16.	Do you have difficulty focusing and concentrating?	
17.	Are you easily chilled, cold hands and feet?	
18.	Do you tend to put on weight easily?	
19.	Do you often wish you were more alert and motivated?	
20.	Do you often have spontaneous muscle twitches, restless leg syndrome?	
	TOTAL	

SECTION 3: Type – T

#	Question	Pts
1.	Low energy and/or lethargy?	
2.	Require lots of sleep, and have trouble getting up in the morning.	
3.	Suffer from depression this may also include post-partum	
4.	A tendency to feel cold, especially in your hands and feet.	
5.	Poor concentration, mental sluggishness, and/or poor memory.	
6.	A family history of thyroid problems?	
7.	Weight gain that began with: the onset of menstruation, after a miscarriage, abortion, birth, and/or menopause.	
8.	Chubby or overweight since childhood	
9.	Tendency to excessive weight gain or inability to lose weight despite normal eating	
10.	Hoarseness and/or gravelly voice.	
11.	Low blood pressure, and/or heart rate.	
12.	Menstrual problems, excessive bleeding, severe cramping, irregular menses, PMS, scanty flow, late or early menarchy (before 12) premenopausal cessation of menstruation.	
13.	Reduced sex drive	
14.	Swollen eyelids and face, general water retention	
15.	Thinning or loss of outside eyebrow hair	
16.	Tendency to have low blood pressure	
17.	Headaches (including migraines)	
18.	High cholesterol, atherosclerosis, and/or high homocysteine	
19.	Lump in throat and/or trouble swallowing pills.	
20.	Slow body movement or speech	
21.	Change in hair or skin (thinning, loss, dryness)	

22.	Weak brittle nails	
23.	Constipation	
24.	Tight tendons, muscle stiffness/tension	
	TOTAL	

SECTION 4: Type –A

#	Question	Pts
1.	Do you feel overworked, pressured or dead-lined?	
2.	Trouble relaxing or loosening up?	
3.	Body tending to be stiff, uptight, tense?	
4.	Easily upset, frustrated, or snappy under stress?	
5.	Often feel overwhelmed or as though you just can't get it all done?	
6.	Weak, shaky at time?	
7.	Sensitive to bright light, noise, or chemical fumes? Need to wear dark glasses?	
8.	Feel significantly worse if you skip meals or go too long without eating?	
9.	Use drugs or food to relax and calm down?	
10.	Have type II Diabetes, hypoglycemia?	
11.	Tend to gain weight around the middle?	
12.	Do you dislike hot weather?	
13.	Reduced sex drive?	
14.	Chronically fatigued: a tiredness that is not usually relieved by sleep?	
15.	Feeling unwell a lot of the time, tend to have colds and flus that hang on?	
16.	Decrease tolerance to cold, feeling cold a lot?	
17.	Small irregular brown spots have appeared on skin?	
18.	Hands and legs get restless-experience meaningless body movements?	
19.	Often become hungry, confused, shaky or somewhat paralysed under stress?	
20.	Water retention, bloating, and digestive problems?	
21.	Feeling "wired" yet "tired" at the same time.	
	TOTAL	