HCMC Integrative Health Clinic
ADULT MEDICAL QUESTIONNAIRE

Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan. Thank you for partnering with us on your path towards optimal health! Add details as needed.

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____
month day year

Work Phone: (_____) _____-_____

Place of Birth:_____

Occupation: _____ City or town & country if not US

Referred by: _____ Height: ___′ ____ ″ Weight: _____ Sex: _____

Appointment Date: _____

1. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister
   _____
   _____

2. Have you lived or traveled outside of the United States? Yes____ No____
   If so, when and where? _____
   _____

3. Have you or your family recently experienced any major life changes or losses? Yes____ No____
   If yes, please comment: _____
   _____

4. On a scale of 1-10, please rate your satisfaction with your:

   Social Life _____ Physical Body: _____ Emotional Expression: _____ Spiritual Life: _____
   Mental Clarity: _____

5. Energy: How is your energy level on a scale of 1-10 at these times during the day:

   8 am? _____ Noon? _____ 4 pm? _____ 8 pm? _____ 11 pm _____

6. Were you a full term baby? _____ Breast fed? _____

7. Any infections as a child? _____ Adult? _____

8. Antibiotic use as child?_____ Adult? _____ Steroids? _____

MEDICAL SYMPTOM QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile **FOR THE PAST 30 DAYS** (if you are dealing with more than one symptom listed below then please circle all that apply):

NAME _____ DATE _____

Please use the scale shown below to describe the severity of your symptom (please total each section)

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 (this section)**

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Dark circles under eyes
_____ Vision problems (excluding near or farsighted)
_____ **TOTAL (this section)**

EARS
_____ Itchy ears
_____ Frequent ear infections
_____ Popping of ears
_____ Ringing in ears
_____ **TOTAL (this section)**

NOSE
_____ Stuffy nose/Excessive mucus formation
_____ Sinus problems
_____ Hay fever/Sneezing attacks
_____ Nose bleeding
_____ **TOTAL (this section)**

MOUTH
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/Discolored tongue, gums, lips
_____ Canker sores
_____ **TOTAL (this section)**

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Excessive hair growth
_____ Excessive sweating/Body odor
_____ Flushing, hot flashes
_____ **TOTAL (this section)**

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ **TOTAL (this section)**

LUNGS
_____ Chest congestion
_____ Asthma, frequent bronchitis
_____ Difficulty breathing
_____ Frequent coughing
_____ **TOTAL (this section)**

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea, loose stools
_____ Constipation, hard/infrequent stools
_____ Bloated feeling
_____ Belching, passing gas, burping
_____ Heartburn/acid taste in mouth
_____ Intestinal/stomach pain
_____ **TOTAL (this section)**

JOINTS / MUSCLE
_____ Pain or aches in joints/Arthritis
_____ Warm, swollen joints
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Muscle weakness
_____ **TOTAL (this section)**

WEIGHT
_____ Excessive eating/drinking
_____ Strong/Excessive craving certain foods
_____ Overweight/Obese
_____ Difficulty losing weight
_____ Water retention
_____ Difficulty gaining weight
_____ **TOTAL (this section)**

ENERGY/ ACTIVITY
_____ Fatigue from mental exhaustion
_____ Fatigue from emotional exhaustion
_____ Hyperactivity (mind or body)
_____ Restlessness (mind or body)
_____ **TOTAL (this section)**

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty making decisions
_____ Speech difficulty
_____ Learning disabilities
_____ **TOTAL (this section)**

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression/Sadness
_____ Obsessive, compulsive behaviors
_____ **TOTAL (this section)**

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ **TOTAL (this section)**

SUM OF ALL SECTIONS ABOVE: _____

Name: _____ Date: _____

HEALTH CONCERNS

*Please describe the **top three (3) symptoms/conditions** you seek to improve at our office **(in order of importance**). Please provide a brief timeline or review of the contributing factors as you see it.*

Problem #1: _____

Problem #2: _____

Problem #3: _____

MEDICAL CARE HISTORY

PREVENTIVE TESTS *Check box if yes and provide date*	DATE	SURGICAL HISTORY *Check box if yes and provide date*	DATE
☐ Full Physical Exam		☐ Appendectomy	
☐ Bone Density		☐ Hysterectomy	
☐ Colonoscopy		☐ Ovaries removed: Right / Left / Both	
☐ Cardiac Stress Test			
☐ EKG		☐ Gall Bladder	
☐ Hemoccult (stool test for blood)		☐ Hernia	
☐ Mammogram		☐ Tonsillectomy/Adenoidectomy	
☐ PAP Smear		☐ Joint Replacement - Knee/Hip	
☐ PSA		☐ Heart Surgery *(type)* _____	
☐ Other _____		☐ Angioplasty or Stent	
		☐ Pacemaker	
		☐ Other _____	

HOSPITALIZATIONS

Date	Reason for Hospitalization

Health Care Team *Please list all providers that manage your care: medical, chiropractic, massage, etc…*

Provider Name	Specialty / Location	Issue(s) Being Managed

MEDICAL HISTORY

DISEASES/DIAGNOSIS/CONDITIONS

Check appropriate box and provide date of onset

☑ *= Past Condition (pc)* ☑ *= Ongoing Condition (oc)*

pc	oc	GASTROINTESTINAL	date of onset
☐	☐	Irritable Bowel Syndrome	
☐	☐	Crohn's Disease	
☐	☐	Ulcerative Colitis	
☐	☐	Gastritis or Peptic Ulcer	
☐	☐	GERD (Acid Reflux)	
☐	☐	Celiac Disease	
☐	☐	Other_____	

pc	oc	CARDIOVASCULAR	date of onset
☐	☐	Heart Attack	
☐	☐	Poor Circulation	
☐	☐	Stroke	
☐	☐	High Cholesterol	
☐	☐	Arrhythmia (irregular beat)	
☐	☐	Hypertension (high blood pressure)	
☐	☐	Heart Valve Disease	
☐	☐	Other _____	

pc	oc	METABOLIC/ENDOCRINE	date of onset
☐	☐	Type 1 Diabetes	
☐	☐	Type 2 Diabetes	
☐	☐	Hypoglycemia (low blood sugar)	
☐	☐	Metabolic Syndrome	
☐	☐	Insulin Resistance or Pre-diabetes	
☐	☐	Obesity/Overweight	
☐	☐	Hypothyroidism (underactive)	
☐	☐	Hyperthyroidism (overactive)	
☐	☐	Polycystic Ovarian Syndrome (PCOS)	
☐	☐	Infertility	
☐	☐	Other _____	

pc	oc	NEUROLOGIC/PSYCHIATRIC	date of onset
☐	☐	Depression	
☐	☐	Anxiety	
☐	☐	Bipolar Disorder	
☐	☐	Headaches	
☐	☐	Migraines	
☐	☐	ADD/ADHD	
☐	☐	Autism	
☐	☐	Multiple Sclerosis	
☐	☐	Seizures	
☐	☐	Eating Disorder (Anorexia/Bulimia)	
☐	☐	Other _____	

pc	oc	GENITAL AND URINARY SYSTEMS	date of onset
☐	☐	Kidney Stones	
☐	☐	Interstitial Cystitis	
☐	☐	Frequent Urinary Tract Infections	
☐	☐	Frequent Yeast Infections	
☐	☐	Erectile or Sexual Dysfunction	
☐	☐	Urinary Incontinence	
☐	☐	Other _____	

pc	oc	MUSCULOSKELETAL/PAIN	date of onset
☐	☐	Osteoarthritis	
☐	☐	Fibromyalgia	
☐	☐	Gout	
☐	☐	Chronic Pain Syndrome	
☐	☐	Other _____	

pc	oc	INFLAMMATORY/AUTOIMMUNE	date of onset
☐	☐	Chronic Fatigue Syndrome	
☐	☐	Autoimmune Disease	
☐	☐	Rheumatoid Arthritis	
☐	☐	Hashimoto's Thyroiditis	
☐	☐	Psoriasis	
☐	☐	Food Allergies	
☐	☐	Environmental Allergies	
☐	☐	Multiple Chemical Sensitivities	
☐	☐	Other _____	

pc	oc	RESPIRATORY DISEASES	date of onset
☐	☐	Asthma	
☐	☐	Chronic Sinusitis	
☐	☐	Bronchitis	
☐	☐	COPD or Emphysema	
☐	☐	Pneumonia	
☐	☐	Sleep Apnea	
☐	☐	Other _____	

pc	oc	SKIN DISEASES	date of onset
☐	☐	Eczema	
☐	☐	Vitiligo	
☐	☐	Acne	
☐	☐	Other _____	

pc	oc	CANCER	date of onset
☐	☐	Lung Cancer	
☐	☐	Breast Cancer	
☐	☐	Colon Cancer	
☐	☐	Ovarian Cancer	
☐	☐	Prostate Cancer	
☐	☐	Skin Cancer	
☐	☐	Other _____	

FEMALE HISTORY

OBSTETRIC HISTORY *(Check box if yes and provide number of times)*

☐Pregnancies _____ ☐ Cesarean _____ ☐ Vaginal Deliveries _____
☐Miscarriage _____ ☐ Abortion _____ ☐ Living Children _____

☐Postpartum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby over 8 lbs.
☐Breastfeeding For How Long? _____

MENSTRUAL HISTORY

Age at first period _____ Menses Frequency _____days Menses Length _____days

Describe your **current** menstrual cycle O Regular O Irregular O Absent
Details: _____
Last Menstrual Period: _____ Date of Last PAP: _____

History of Abnormal PAP? O Yes O No If yes, date of abnormal PAP: _____

Current contraception? O None O Condom O Diaphragm O IUD O Vasectomy O Birth Control Pill

Total years of hormonal contraception use? _____

WOMEN'S DISORDERS/HORMONAL IMBALANCES (check all that apply)

☐Fibrocystic Breasts ☐Endometriosis ☐ Fibroids ☐Infertility
☐Painful Periods ☐ Heavy Periods ☐ PMS

Are you in Menopause (no menses in last 12 months)? O No O Yes (if yes, What age? _____)
If yes, O Natural O Surgical removal of ovaries

Current use of hormone replacement therapy? O None
(How Long? _____) O Traditional Prescription
(How Long? _____) O Bioidentical Hormone Replacement Therapy

Previous use of hormone replacement therapy? O None
(How Long? _____) O Traditional Prescription
(How Long? _____) O Bioidentical Hormone Replacement Therapy

Menopausal Symptoms: *Check all that apply*

☐ Hot Flashes ☐Mood Swings ☐Concentration/Memory Problems ☐ Vaginal Dryness
☐ Night Sweats ☐ sleep problems ☐Postmenopausal bleeding ☐ Loss of Control of Urine
☐ Headaches ☐ Palpitations ☐Weight Gain ☐Depression or Anxiety

MALE HISTORY

Have you had a PSA done? O No O Yes (Date of last PSA? _____)
PSA Level O 0-1 O 2-4 O 5-10 O >10

Check all that apply

☐Erectile Dysfunction
☐Nocturia (urination at night) How many times per night? _____

☐ Urgency/Hesitancy/Change in Urinary Stream
☐ Enlarged Prostate

DIGESTIVE/DIETARY HISTORY

Please describe your typical daily diet by indicating your usual daily servings:

Vegetables:	_____	Dairy:	_____
Fruits:	_____	Potatoes:	_____
Beans:	_____	Fats/Oil:	_____
Nuts/Seeds:	_____	Fast Food:	_____
Whole Grains:	_____	Refined Grains:	_____
Animal Protein:	_____	Processed Foods:	_____

Are you on a special diet? _____

Overall, do you feel that you eat . . .

(check all that apply)

O Too Much O Too Little O Just enough
O Very Healthy O A Little Unhealthy O Unhealthy

Do you feel like you digest your food well? O Yes O No

Do you feel bloated after meals? O Yes O No

If yes, O within 30 min after eating O after 1-2 hours of eating

Were there years where you took more than 3 courses of antibiotics per year? O Yes O No

Do you experience frequent yeast infections or toe fungal infections/athlete's foot? O Yes O No

Do you get sick from strong smells, chemicals or medications easier than most people? O Yes O No

Are there some foods to which you are allergic, intolerant or just seem to bother you?

Explain: _____

Do you suffer from allergies? O Environmental O Food

If environmental, are they. . . O Seasonal O All Year Long

Do you ever find blood in your stool? O Yes O No

How many bowel movements do you have in a typical day? O <1 O 1 O 2 O 3 O 4 O _____

If you answered <1, how often do you have a bowel movement? Every _____ days

Describe your typical bowel movement *(check all that apply)*

O Hard	O Soft	O Alternating diarrhea/constipation
O Pellet-like	O Loose	O Mucus in stool
O Requires straining	O Watery	O Undigested food in stool
O Complete	O Incomplete	O Strange color/odor

If you experience any digestive issues, when did they begin?

O Last 3-6 months O Since childhood
O Last 6-12 months O Can't remember
O _____ years ago

Have you ever been referred to a Gastroenterologist? O Yes O No

Explain: _____

Do you feel safe at home? Yes No *Any history of abuse? Yes No*

SMOKING

Currently Smoking? O Yes O No How many years? Packs per day:

Attempts to quit: Using what methods: _____

Previous Smoking? O Yes O No How many years? Packs per day:

Quit Date: _____

2nd Hand smoke exposure? O None O Low O Medium O High

Heavy metal exposure? What types?

ALCOHOL INTAKE

How many drinks currently per week? *(1 drink = 5oz wine, 12 oz. beer, 1.5 oz. liquor)*

O None O 1-3 O 4-6 O 7-10 O >10; O throughout the week O weekends mostly

Do you frequently (more than 2x/week) take:

O >1 drink per day for females

O >2 drinks per day for males

Previous alcohol intake? O None O Mild O Moderate O High

Do you ever feel guilty about your alcohol consumption? O Yes O No

Do you notice a tolerance to alcohol (you can "hold" more than others)? O Yes O No

Do you notice you 'feel' your alcohol at very low amounts? O Yes O No

OTHER SUBSTANCES

Caffeine intake

Cups per day: O Coffee: _____ O Tea: _____ (o Herbal O Non-Herbal)

Caffeinated or Diet Beverages per day O None O 1 O 2 O 3 O ≥4

List favorite type (e.g. Diet Coke, Pepsi, Red Bull, Monster, etc.)

Do you often take caffeine to avoid fatigue? O Yes O No

EXERCISE

Current Exercise Program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency/week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Yoga/Pilates			
Sports/Leisure Activities *(golf, tennis, rollerblading, etc.)*			

Do you feel unusually fatigued after exercise? O Yes O No

If yes, please describe:

Do you usually sweat when exercising? O Yes O No

[redacted]

LIFESTYLE INFORMATION

STRESS/COPING

Have you ever sought counseling? O Yes O No

Do you feel you have an excessive amount of stress in your life? O Yes O No

Do you feel you can manage the stress in your life? O Yes O No

Do you feel you make unhealthy choices due to high stress? O Yes O No

Daily Stressors: *(Rate on a scale of 1-10 1 = lowest, 10=highest)*

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? O Yes O No

Check all that apply: O Yoga O Meditation O Breathing O Tai Chi O Prayer O Other _____

SLEEP/REST

How likely are you to doze off or fall asleep in the following situations using the scale below?

0 = Would never doze *2 = Moderate chance of dozing*

1 = Slight chance of dozing *3 = High chance of dozing*

Sitting and reading	O 0	O 1	O 2	O 3
Watching television	O 0	O 1	O 2	O 3
Sitting inactive in a public place (ex, a theater or meeting)	O 0	O 1	O 2	O 3
Lying down to rest in the afternoon when circumstances permit	O 0	O 1	O 2	O 3
Sitting and talking to someone	O 0	O 1	O 2	O 3
Sitting quietly after a lunch without alcohol	O 0	O 1	O 2	O 3
In a car, while stopped for a few minutes in traffic	O 0	O 1	O 2	O 3
As a passenger in a car for an hour without a break	O 0	O 1	O 2	O 3

Average number of hours you sleep per night? O > 10 O 8-10 O 6-8 O < 6

Do you have trouble falling asleep at night? O Yes O No

If yes, how long does it usually take to fall sleep? _____

Do you have trouble staying asleep at night? O Yes O No

If yes, how long are you awake throughout the night? _____

How many times do you awaken throughout the night? _____

Please list any sleep aids (prescription or natural) or other methods tried: _____

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:

Educate yourself on your condition	O5	O4	O3	O2	O1
Significantly modify your diet	O5	O4	O3	O2	O1
Modify your lifestyle (work demands, sleep, etc.)	O5	O4	O3	O2	O1
Practice a relaxation technique	O5	O4	O3	O2	O1
Take several nutritional supplements each day	O5	O4	O3	O2	O1
Engage in regular exercise	O5	O4	O3	O2	O1
Have periodic lab tests to assess your progress	O5	O4	O3	O2	O1

Comments _____

Please place age at diagnosis where appropriate. For multiple siblings/children, place multiple checks age.

	Father	Brother	Sister	Child (ren)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Uncle(s)	Aunt(s)
Age (if still alive)										
Age at death										
Colon Cancer										
Breast Cancer										
Other Cancers - List Type _____										
Heart Disease										
Stroke										
Hypertension										
Obesity/Overweight										
Diabetes										
High Cholesterol										
Arthritis (<60 years old)										
Multiple Sclerosis										
Rheumatoid Arthritis / Lupus / Psoriasis										
Ulcerative Colitis / Crohn's Disease										
Irritable Bowel Syndrome (IBS)										
Celiac Disease										
Asthma / Chronic Bronchitis										
Eczema/Hives										
Food Allergies or Sensitivities										
Environmental Sensitivities										
Multiple Chemical Sensitivities										
Dementia or Parkinson's										
Substance Abuse (alcoholism, drugs)										
Depression										
Anxiety										
ADHD										
Autism										
Thyroid Disorders										
Recurrent Miscarriage/infertility										
Seizures										
Other _____										

MEDICATION HISTORY

Attach separate page as needed

CURRENT MEDICATIONS

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Use?

PREVIOUS MEDICATIONS (*Last 10 years)*

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Stopping?

CURRENT NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

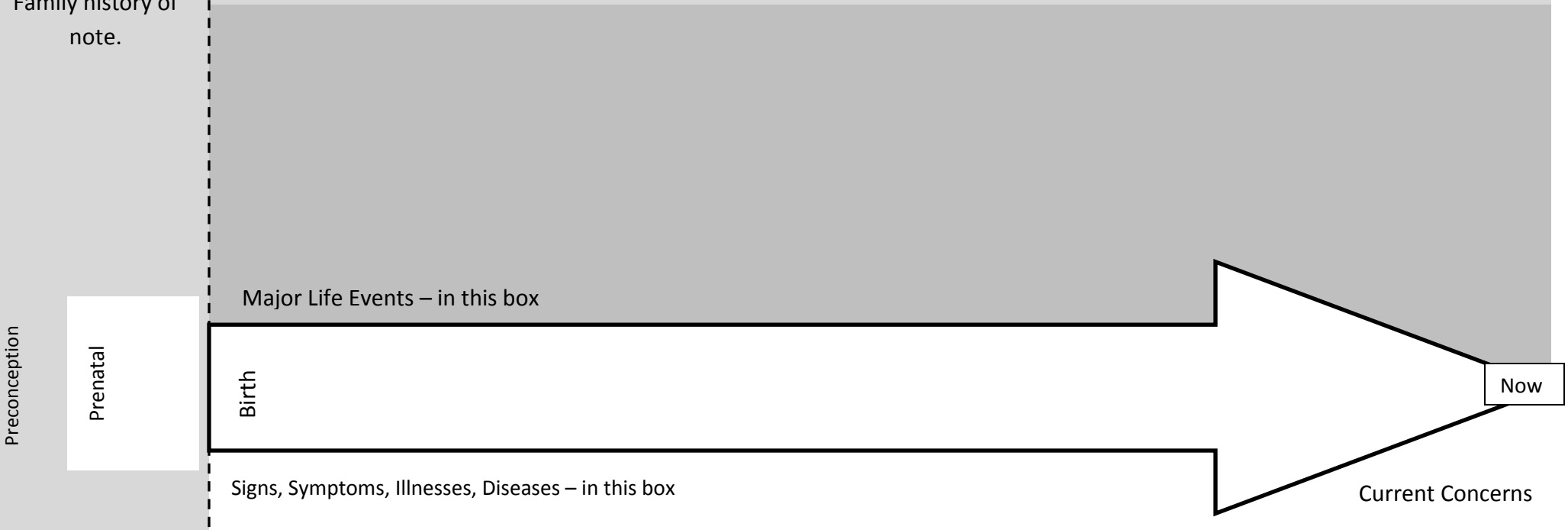
Supplement	Strength	Dosing Schedule	Start Date (month/year)	Brand of Supplement

ALLERGIES (ENVIRONMENTAL, FOOD & DRUGS)

Allergen	Associated Symptoms	Treatment needed, if applicable

Family situation at time of birth; Family history of note.

Please write your major life events and health concerns below, including things such as marriage, parental divorce, death, birth of a child, etc or onset of asthma, fatigue, episode of pneumonia, etc. (Write above the heading Major Life Events and below the Signs, Symptoms, Illnesses, etc)



Name: _____ Date: _____ Signature: _____