Community Therapeutix
601B Broad Street
New London, CT 06320

ADULT HEALTH QUESTIONNAIRE

NAME _____ DOB _____

REFERRED BY _____

LIST DR./DRS. YOU ARE CURRENTLY SEEING _____

_____

PLEASE LIST YOUR HEALTH CONCERNS

1.	4.
2.	5.
3.	6.

MEDICAL HISTORY

Have you ever had any of the following? If so, please check (√). Indicate approximate date of onset and elaborate below if necessary.

_____Allergies
_____Anemia
_____Appendicitis
_____Arthritis
_____Asthma
_____Attempted Suicide
_____Bone or Joint Disease
_____Bursitis
_____Cancer
_____Chronic Back Problems
_____Chronic Bladder Infections
_____Chronic Ear Infections
_____Chronic Sinus Infections
_____Chronic Vaginitis
_____Colitis
_____Depression
_____Diabetes
_____Eating Disorder
_____Eczema
_____Edema (Fluid Retention)
_____Frequent Antibiotic Use
_____Frequent Steroid Use (prednisone, etc.)
_____Gall Bladder Disease
_____Gout
_____Hay Fever
_____Head Injury
_____Heart Disease
_____Hepatitis
_____Herpes
_____High/Low Blood Pressure
_____Hives
_____Hypoglycemia
_____Jaundice
_____Kidney Infections
_____Kidney Stones
_____Liver Disease
_____Lyme Disease
_____Migraine Headaches
_____Mononucleosis
_____Nervous Breakdown
_____Neurological Disorder
_____Occupational Exposure to Toxic Substances
_____Other Physiological Disorders
_____Other Skin Diseases
_____Parasites
_____Psoriasis
_____Seizure Disorder
_____Sexually Transmitted Diseases (Chlamydia, warts, herpes, gonorrhea, syphilis)
_____Stroke
_____Substance Abuse/Addiction
_____Thyroid Disease
_____TIA's (mini strokes)
_____Ulcers
_____Warts
_____OTHER_____

Other (cont.)_____

Hospitalization (date and type of illness/procedure)

1.
2.
3.

Allergies to drugs, food, other substances (please describe) _____
_____
_____

Practitioner Reviewed:_____ Date:_____

Review of Systems

Please indicate the following: **N** = a condition you have **NOW** **P** = a condition you have had in the **PAST**

Skin

Dry _____ Oily_____

Itching_____

Rashes_____

Hives_____

Flushes Easily_____

Bruises Easily_____

Warts_____ Moles_____

Where_____

Hair Loss _____

Nails: Soft_____ Dry/Brittle_____

Do you bite your nails? Yes___ No___

Head

Migraines_____ Headaches_____

Location of pain_____

Worse: Light___ Noise___ Odors___

Head Injury_____

Describe_____

TMJ_____

Dizziness_____ Fainting_____

Seizures_____

Eyes

Vision Disturbances_____

Dryness_____ Tearing_____

Pain_____

Styes_____

Infections_____

Sensitive to light_____

Floaters_____

Ears

Discharge_____

Pain_____ Itch_____

Impaired Hearing_____

Ringing_____

Nose

Seasonal Allergies_____

Drainage_____

Color: Clear___ Yellow___ Green___

Texture: Runny_____ Thick_____

Postnasal Drip_____

Clears Throat Often_____

Stuffiness_____

Sneezing_____

Sinus Infections_____

Nosebleeds_____

Mouth

Dryness_____ Salivation_____

Tongue: Sore_____ Coated_____

Canker Sores_____

Fever Blisters_____

Throat/Neck

Pain in Throat_____

Glands Enlarged_____

Difficulty swallowing_____

Change in voice_____

Respiratory

Frequent colds and infections_____

Pneumonia_____

How many times_____

What side: R_____ L_____

Bronchitis_____

Cough_____

Spit up blood_____ Mucous_____

Asthma_____ Wheezing_____

Shortness of breath_____

Positive TB Test Ever? _____

Cardiovascular

Chest Pain_____

Heart Palpitations/Racing_____

Heart disease_____

High_____ Low_____ Blood Pressure

Varicose Veins_____

Leg Pains_____ Cramps_____

Ankle Swelling_____

Cold Hands_____ Feet_____

High Cholesterol? _____

High Triglycerides? _____

Digestion

Bowel Movement

x per day: 1-2___ 2-3___ 3-4___ or

x per week: 1-2___ 2-3___ 3-4___

Size: Sm_____ Med_____ Lg_____

Color: Brown___ Tan___ Rust_____

Texture: Dry_____ Hard_____

Set/Loose_____ Pellets_____

Float_____ Sink_____

Stools with Mucous_____ Blood_____

Hemorrhoids

Bleeding___ Painful___ Itching___

Stool Incontinence_____

Bowel Disease_____

Liver/Gallbladder Disease_____

Ulcer_____

Heartburn_____

Bloating_____

Belching_____

Gas/Flatus_____

Nausea/Vomiting_____

Pain/Cramps_____

Urinary

Difficult Urination_____

Painful Urination_____

Incontinence/Dribbling_____

Blood in Urine_____

Frequent Urination Day_____

Night _____

Frequent Bladder Infections_____

Bedwetting_____

NAME _____DOB_____

Women Only

History of Sexual Abuse _____
Frequent Yeast Infections_____
Vaginal Discharge_____
Age Period Began _____
Regular Periods: Yes_____ No_____
Flow:
Heavy_____ Medium_____ Light_____
Spotting _____
Cramps _____
Clots: _____ Days of Flow_____
PMS? _____ Endometriosis? _____ PID? _____
Fibroids_____
Change in Sex Drive _____
# of Pregnancies _____
# of Childbirths _____
Complications _____
Miscarriages _____
Vaginal Dryness _____
Hot Flashes _____
Breasts:
Lumps _____ Cysts_____
Discharge_____ Pain_____

Men Only

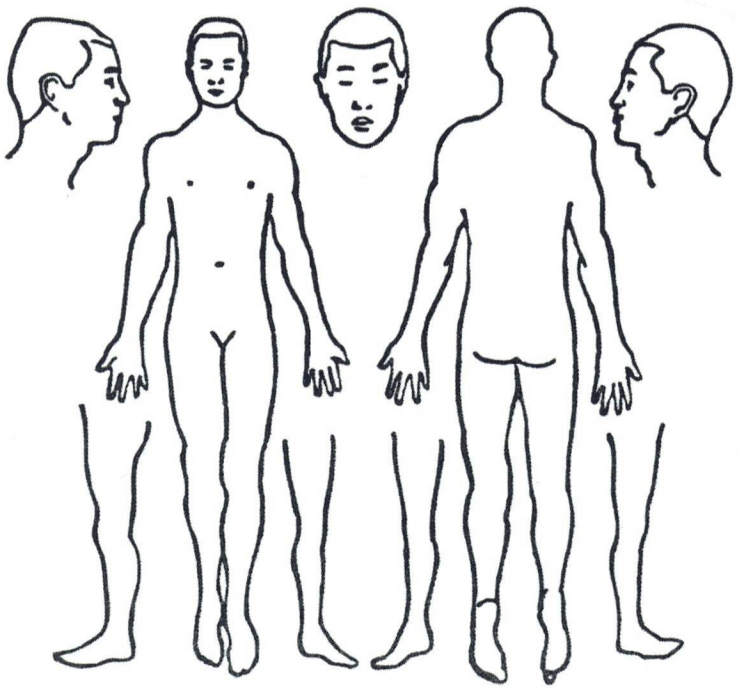
Change in Force of Urine Stream_____
Difficulty Starting Urine_____
Pain/Lump in Scrotum_____
Change in Sex Drive _____
Children _____
Age/Gender _____
_____
_____
Impaired Fertility _____
Sexually Transmitted Diseases _____
History of Sexual Abuse _____

Sleep

Difficulty falling asleep _____
Frequent waking _____
Time: 12-1am_____ 1-2 am_____ 3-4 am_____ 4-5 am _____
Nightmares _____
Restlessness_____
Sleep Position Preferred _____
Wake refreshed? Yes _____ No_____
Feel Hot _____ Cold _____ in bed
Stick feet out of covers? Yes _____ No_____
Wear socks to bed? Yes_____ No_____

Muscular/Skeletal

Back Pain _____
Pain in Muscles/Joints/Bones _____
Stiffness/Swelling _____
Muscle Weakness/Tremor _____
Numbness/Tingling_____
Shooting Pain _____
Spasms _____ Twitches_____
Any side worse: R_____ L_____
Ever broken any bones? _____
Which _____
Every sprained any joints? _____
Which _____
Please indicate areas of pain/discomfort and describe below:
_____
_____
_____
_____



Mental/Emotional

Please list adjectives that best describe you:

1. _____ 2._____ 3._____

4. _____ 5._____

Please mark emotions often felt:

Joy _____ Anger_____ Fear_____ Anxiety_____ Sadness_____

Do you experience mood swings? Yes _____ No_____

Have you ever lost a loved one? Yes_____ No_____

Please describe _____

Do you cry easily? Yes_____ No_____

Do you like consolation? Yes_____ No_____

Please mark phobias:

3 = Very Strong 2 = Strong 1 = Medium

Heights_____ Bridges_____ Crowds_____ Water_____

Claustrophobia_____ Dark_____ Spiders_____

Being Alone_____ Public Speaking_____

Flying_____ Thunderstorms_____ Other_____

Any problems with Memory_____ Mental Clarity_____

Focus/Attention Span_____

General

What is your level of energy, from 1 to 10, 10 being optimal_____?

Does it change throughout the day? Yes_____ No_____

When _____

Is it better_____ or worse _____ from exercise?

Do you tend to feel hot / warm / neutral / cool / cold? (Circle one)

Are you sensitive to heat / cold / both? (Circle one)

Do you perspire easily? Yes _____ No_____

With exertion? Yes_____ No_____

During the night? Yes _____ No_____

Appetite: High_____ Low_____ Average _____

Recent Change in Appetite? _____ Thirst? _____ Weight? _____

Thirst: High_____ Low_____ Average_____

For: Hot_____ Cold_____ Room Temp_____

Lifestyle Factors: Indicate <u>Amounts</u>

Exercise_____

Drink Coffee_____

Alcohol_____

Use Tobacco / Recreational Drugs_____

IV Drug Use_____

Foods

Please put a number **only next to the foods you crave:**

3 = Very Strong 2 = Strong 1 = Medium

Sweets_____ Chocolate_____ Salt_____ Sour_____

Hot/Spicy_____ Meats_____ Milk_____ Cheese_____

Fats_____ Eggs_____ Butter_____ Potato Chips_____

Vinegar_____ Lemons_____ Pickles_____ Coffee_____

Alcohol_____ Other_____

Please put a number **only next to the foods you dislike:**

3 = Very Strong 2 = Strong 1 = Medium

Liver_____ Oysters_____ Onions_____ Eggplant_____

Lima Beans_____ Eggs_____ Mile_____ Other_____

_____

Please List foods that cause you digestive discomfort:

1._____ 2. _____ 3. _____

Please list your symptoms after you eat these foods:

1._____ 2. _____ 3. _____

Current Medicines: (Please be specific with dosages)

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

Current Supplements (Please be specific with dosages)

1. _____
2. _____
3._____
4._____
5._____
6. _____
7. _____
8._____
9._____
10._____

24 HOUR DIET RECALL:

Breakfast	Lunch	Dinner
Snack	Snack	Snack