Patient Questionnaire

HEALTHSPAN
FOR A LIFESPAN OF HEALTH
1900 W. 75TH ST. – SUITE 250
PRAIRIE VILLAGE, KS 66208
WWW.HEALTHSPANKC.COM

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) _____

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…
□ Penicillin □ Sulfa drugs	□ Any other drugs—List:	□ Any foods—List:
□ Aspirin □ Codeine □ Morphine		
□ Other antibiotics—List:	□ adhesive tape □ alcohol	
	□ iodine contrast	□ 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

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

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

Please list any other diseases or conditions:

Surgery

Have you had removed…	Have you ever had a transfusion of…	Have you…
□ Tonsils	□ Blood □ Plasma	□ been hospitalized for any illness
□ Appendix	Have you…	Explain:
□ Gall Bladder	□ had a hernia repaired	
□ Uterus	□ had any other operations	
□ Right ovary □ Left ovary	Explain:	

Health Maintenance

Have you had…	Have you had…	Have you had…
□ Complete childhood immunizations	□ Rhogam injection	□ Cholesterol screening
If not, age they were stopped:	□ any other vaccines? List:	□ Thyroid hormone screening
□ a flu shot (ever) Year:		□ Rectal exam
□ a tetanus shot within last 10 years		□ Colonoscopy/Flexible Sigmoidoscopy

Habits

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

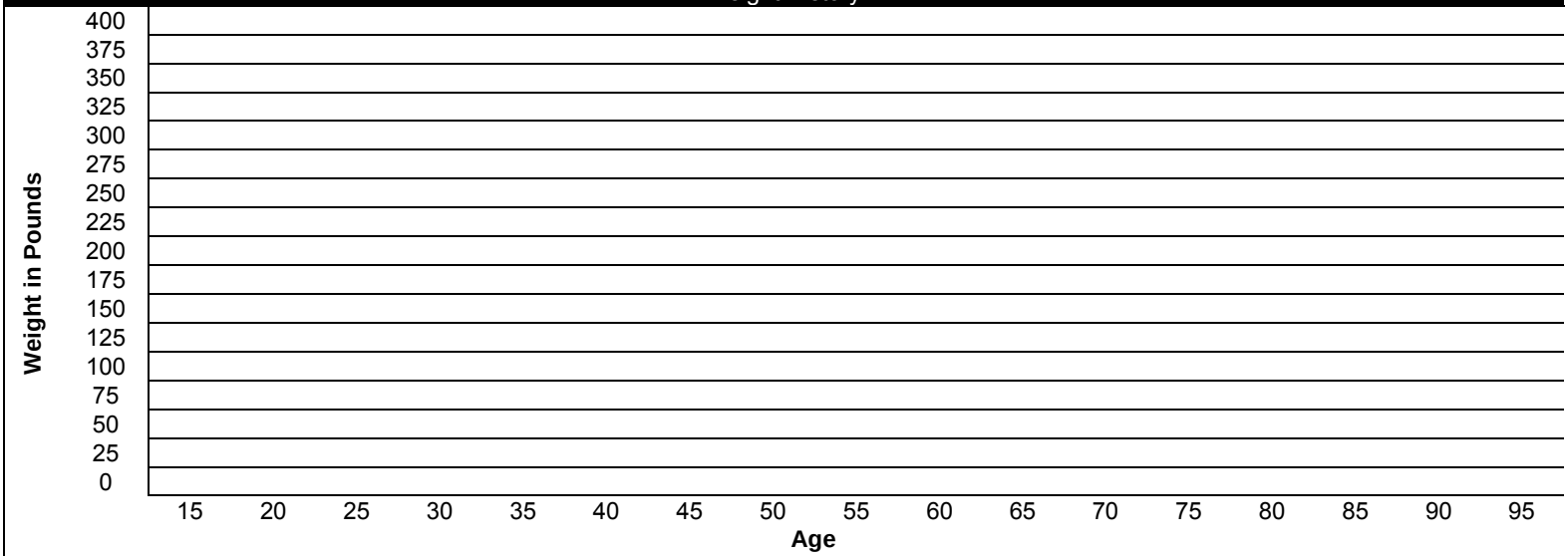
For Women Only

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

Cardiovascular Risk Assessments

□ I am a man over 45 years old
□ I am a woman over 55 years old
□ My father, brother or son had heart disease before age 45 – OR – my mother, sister or daughter had heart disease before age 55
□ I currently smoke
□ My good cholesterol is less than 40 mg/dl

Weight History



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 <u>every 15 minutes</u> spent	*Give 1 point for <u>every 15 – 20 minutes</u> spent*	*Give 1 point for <u>every 30 minutes</u> 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 <u>30 – 40 minutes</u> spent	___ Bicycling 5 miles
Give 1 pojnt for <u>every 45 – 60</u> 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:

Favorite Snack Food:

Favorite Vegetable

Number of Vegetable Servings Eaten Daily:

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:

□ Coffee □ Soda Pop □ Tea

□ Milk □ Yoghurt □ Cheese

□ Margarine, Earth Balance

□ Energy Drinks

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: _____

_____ Date: _____

B.S. Klug (Signature)

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