North Hills Natural Medicine, LLC
Questionnaire

Cancellation Policy

If you wish to cancel your initial appointment, please notify us at least 2 business days in advance to avoid a late cancellation charge.

Please answer the following questions as completely as possible. We are interested not only in your major symptoms but also minor or intermittent symptoms as well. All of this information together will allow us to better help you.

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Questionnaire

Name: _____ Age: _____

Address: _____

_____

_____

Birthdate: _____ Phone: _____

Referred by: _____

Main Problems/Symptoms (in order of importance)

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Is your problem the subject of legal proceedings or a Workman's Compensation Case? Yes ___ No ___

Prior Medical Diagnoses (and their treatment):

1. _____

2. _____

3. _____

4. _____

Prior surgery (including dental surgery), trauma or accident:

1. _____

2. _____

3. _____

4. _____

Medications:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Medications (continued):

7. _____ 8. _____

9. _____ 10. _____

Allergies: (meds/food/environmental) _____ _____

_____

Vitamin/Mineral and other Nutritional supplements:

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Occupation: what is your job?_____

Stress Level none___ mild___ moderate___ severe__

love it ___ it's ok___ don't like it___ hate it___

Marital Status (circle one) married partnered single divorced separated

Children: number___ ages _____

Habits: Smoke (cigarettes or packs per day) _____

Alcoholic beverages (quantity per day or week) _____

Caffeine: number of cups of coffee/day _____

and/or glasses or cans of soda per day)

Symptoms or Complaints

None	Mild	Mod	Severe	Symptoms (current or recurrent)
☐	☐	☐	☐	cold intolerance
☐	☐	☐	☐	heat intolerance
☐	☐	☐	☐	fever
☐	☐	☐	☐	fatigue
☐	☐	☐	☐	headaches
☐	☐	☐	☐	migraines
☐	☐	☐	☐	overly sensitive to odors
☐	☐	☐	☐	ringing in the ears
☐	☐	☐	☐	hearing loss
☐	☐	☐	☐	calf or foot cramps
☐	☐	☐	☐	muscle twitching
☐	☐	☐	☐	difficulty swallowing
☐	☐	☐	☐	constipation (no.of BM_____per day or wk (circle one))
☐	☐	☐	☐	muscle weakness
☐	☐	☐	☐	muscle aches or pains

None	Mild	Mod	Severe	Symptoms (current or recurrent)
☐	☐	☐	☐	stiffness
☐	☐	☐	☐	anxiety
☐	☐	☐	☐	irritability
☐	☐	☐	☐	depression
☐	☐	☐	☐	panic attacks
☐	☐	☐	☐	light headedness upon standing
☐	☐	☐	☐	dizziness (room spinning)
☐	☐	☐	☐	seizures
☐	☐	☐	☐	difficulty concentrating
☐	☐	☐	☐	numbness or tingling
☐	☐	☐	☐	overweight (desired wt loss- lbs)
☐	☐	☐	☐	underweight (desired wt gain- lbs)
☐	☐	☐	☐	poor appetite
☐	☐	☐	☐	cravings
☐	☐	☐	☐	gums bleed
☐	☐	☐	☐	dry mouth
☐	☐	☐	☐	dry eyes
☐	☐	☐	☐	sore tongue
☐	☐	☐	☐	cracking at corners of mouth
☐	☐	☐	☐	intolerance of lactose
☐	☐	☐	☐	intolerance of dairy products
☐	☐	☐	☐	intolerance of fatty foods
☐	☐	☐	☐	intolerance of wheat
☐	☐	☐	☐	heartburn
☐	☐	☐	☐	abdominal pain or tenderness
☐	☐	☐	☐	bloating or gas
☐	☐	☐	☐	burping
☐	☐	☐	☐	diarrhea
☐	☐	☐	☐	undigested food in stool
☐	☐	☐	☐	blood in stool
☐	☐	☐	☐	psoriasis
☐	☐	☐	☐	eczema
☐	☐	☐	☐	skin rash
☐	☐	☐	☐	acne
☐	☐	☐	☐	easy bruising
☐	☐	☐	☐	dry skin
☐	☐	☐	☐	itchiness of skin (or after shower)
☐	☐	☐	☐	dry scalp/dandruff
☐	☐	☐	☐	oily skin
☐	☐	☐	☐	dry hair
☐	☐	☐	☐	excessive callous on hands or feet
☐	☐	☐	☐	poor night vision
☐	☐	☐	☐	excessive ear wax
☐	☐	☐	☐	hair loss (other than male pattern loss)
☐	☐	☐	☐	cracking or peeling nails
☐	☐	☐	☐	white spots or lines on nails
☐	☐	☐	☐	decreased sense of taste or smell
☐	☐	☐	☐	nasal stuffiness
☐	☐	☐	☐	sinus infections
☐	☐	☐	☐	bad odor in nose
☐	☐	☐	☐	bad breath
☐	☐	☐	☐	environmental allergies
☐	☐	☐	☐	recurrent sore throat
☐	☐	☐	☐	difficult or stressful childhood
☐	☐	☐	☐	difficult or stressful episodes as adult
☐	☐	☐	☐	chronic stress as an adult
☐	☐	☐	☐	wheezing
☐	☐	☐	☐	palpitations
☐	☐	☐	☐	rapid pulse
☐	☐	☐	☐	difficulty breathing

None	Mild	Mod	Severe	Symptoms (current or recurrent)
☐	☐	☐	☐	kidney stones
☐	☐	☐	☐	urinary urgency
☐	☐	☐	☐	urinary leaking
☐	☐	☐	☐	urinary hesitancy
☐	☐	☐	☐	urinary bleeding
☐	☐	☐	☐	infertility
				Male only:
☐	☐	☐	☐	prostate enlargement
☐	☐	☐	☐	impotence
				Female only:
☐	☐	☐	☐	vaginal discharge or odor
☐	☐	☐	☐	breast lumps
☐	☐	☐	☐	breast cysts or fibrocystic disease
☐	☐	☐	☐	premenstrual bloating
☐	☐	☐	☐	premenstrual breast tenderness
☐	☐	☐	☐	premenstrual fluid retention
☐	☐	☐	☐	premenstrual mood swings
☐	☐	☐	☐	premenstrual constipation
☐	☐	☐	☐	premenstrual food cravings
☐	☐	☐	☐	premenstrual diarrhea
☐	☐	☐	☐	premenstrual fatigue
☐	☐	☐	☐	menstrual cramps
☐	☐	☐	☐	heavy periods
☐	☐	☐	☐	irregular periods
☐	☐	☐	☐	no periods
☐	☐	☐	☐	scanty periods
☐	☐	☐	☐	spotting between periods
☐	☐	☐	☐	endometriosis
☐	☐	☐	☐	ovarian cyst
☐	☐	☐	☐	fibroids
☐	☐	☐	☐	infertility

Please indicate your typical eating habits:
Breakfast: _____
_____
_____
Lunch: _____
_____
_____
Dinner: _____
_____
_____
Snacks: _____
_____
_____

I generally crave (circle all that apply): sugar carbs (bread, pasta, cereal) salt none

Diseases that run in your family (e.g.- diabetes, high blood pressure, heart disease): _____
_____
_____