Intake Questionnaire

1. Primary Complaint (what do you want to focus on)?
   _____
2. If there is pain associated with this problem, what is your pain level on a scale of 1 to 10, with 10 being the worst? _____
3. Body Temperature: Do you normally run hot or cold? Do you feel like you're taking clothing off or putting it on? Do you experience night sweats or spontaneous sweating?
   _____
4. Vision: Do you have any issues with vision (ie. floaters, auras, etc.)? If you wear glasses or contact lenses, are you near-sighted, far-sighted, bifocals, reading only?
   _____
5. Hearing: Do you have any issues with hearing (buzzing, ringing, which ear)? Please describe. _____
6. Describe your daily diet for me: Do you eat 3 or more meals per day? Do you eat breakfast regularly? Do you eat lots of fruits and vegetables? Are you a vegan or vegetarian? Do you fast regularly? What kinds of meat do you eat and how frequently? Do you eat a lot of fast food / processed foods? How much water do you drink daily? Do you drink coffee, tea or soda? If so, how much per day? Do you crave certain foods on a regular basis (ie. salty, sweet, etc.)?
   _____
   _____
   _____
   _____
   _____
7. How often do you have a bowel movement? Do you lean towards constipation or diarrhea at all? Is there any blood or mucus in the stools? Are the stools difficult to pass? Are the stools loose or watery?
   _____
   _____
8. Do you wake up at night to urinate? If so, how often? Any issues with urinary tract infections? Any history of urinary or kidney stones?
   _____

9. Describe your sleep. Approximately how many hours of sleep per night on average? Is your sleep restless? Do you dream? Do you have nightmares or night terrors? Do you wake up feeling rested or fatigued?

   _____

   _____

10. Are there any issues in your chest area: Palpitations? Chest pain? Do you have a pacemaker?

    _____

11. Do you have bloating of gassiness on a regular basis? _____
12. Do you suffer from any type of autoimmune disease (ie. Crohn's, IBD, fibromyalgia, diabetes, etc.)? If so, how long ago were you diagnosed?

    _____

    _____

13. Do you suffer from any type of sexual dysfunction or sexually transmitted diseases? Is your libido normal?

    _____

14. Tell me about your emotional health: Do you cry a lot? Sigh a lot? Get angry frequently? Depression? Anxiety? Stress? How do you deal with your emotions?

    _____

    _____

15. Does your primary complaint limit you in any way and if so, how?

    _____

    _____

16. Do you smoke? If so, how much per day / week? _____
17. Do you drink? If so, how much per day / week? _____
18. Are there any additional complaints or areas you would like to work on?

    _____

    _____

    _____