CONFIDENTIAL PATIENT QUESTIONNAIRE

NAME: _____ DATE: _____

Please write down, fully and honestly, answers to the following questions.
All information provided by you remains completely confidential.

Please use separate sheets if insufficient space.

GENERAL QUESTIONS ABOUT YOURSELF.

1. What type of weather makes you feel better or worse? Describe your feelings. Sunny, cloudy, humid, dry, rainy, windy, stormy, etc.

2. How do hot and cold things affect you? Fans, air-conditioning, heating, open fire, cold/hot food and drinks, etc.

3. Are you affected by different phases of the moon? If so, how?

4. How does natural or artificial light affect you?

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5. How does the darkness affect you?

6. At what time of the day or night do you feel better or worse? Describe your feelings.

7. Do you feel hot or cold? In which parts of the body? When and where? Upon waking up, moving about, during/after drinking or eating, in bed, etc.

8. In which position/s are you most uncomfortable and comfortable? Standing, sitting, kneeling, squatting, lying on side/s, back, stomach, driving a car, etc.

9. Are you restless, fidgety, preferring to move about, or better sitting / lying around?

10. Where do you perspire the most and the least? What makes you perspire? What is the smell, feel and colour of the perspiration? Any stains on clothing?

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11. How do noises affect you? What kinds of noises affect you the most?

12. How sensitive is your sense of smell? What kinds of odours do you like / dislike the most?

13. What are your favourite foods? Favourite drinks? Hot, warm, cold food / drink? Preferred tastes – salty, sweet, sour, bitter, hot, spicy, bland, etc? Which foods / drink do you avoid, or disagree with you? How do you feel and what happens to you if you consume such food / drink?

14. What sort of clothing do you prefer to wear? Some examples include collars, neckbands or ties around your neck, tight or loose clothing, enclosed shoes, sandals or bare feet, long or short sleeves, woollen, cotton, nylon, silk, leather.

15. How are you with touching people? How about others touching you?

16. How do you feel when you're alone? What do you prefer to do when alone? How do you feel in company? How do you behave or react when in company? Which do you prefer?

17. How do you feel about going out in general? How do you feel about coming home?

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18. How is your sleep? How do you get yourself most comfortable when falling sleep – lying on side, back, front, number of pillows, type of blanket, etc? How easily do you fall asleep? What time do you go to sleep? At what time(s) do you wake and how long do you stay awake? Why do you wake? Why do you stay awake? At which part of the night do you enjoy the best sleep? How do you feel when you wake up to go to work, etc?

19. Do you remember dreams? What sort of dreams do you have? Are there any repetitive dreams? If so, how long have you had them? How do you feel in your dreams?

20. How do you see yourself? How would you describe yourself?

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YOUR MEDICAL HISTORY. These are in addition to your "Personal Medical History."

Please provide detailed answers to the questions below, if you have not already done so.

Have you ever had, or do you have any of the following?

VACCINATIONS: When, where, types, reactions.

AMALGAMS ("Silver" or mercury fillings) AND ROOT CANALS: How many, where and when performed.

Also any amalgams that have been removed – when, where, and procedures used.

SCAR TISSUE: After operations, accidents, burns, etc. When, where, causes, and treatment.

ALL CURRENT PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS AND REMEDIES, SUPPLEMENTS, RECREATIONAL SUBSTANCES TAKEN INTERNALLY, INHALED OR APPLIED EXTERNALLY. PLEASE PROVIDE ACCURATE DETAILS.

Examples include prescription drugs, over-the counter drugs, remedies, medicines from all other practitioners, including naturopaths, chiropractors, Chinese herbalists, etc., dental mouthwashes, toothpaste, health food store medications, all creams, salves, oils, ointments, herbs and herbal teas, dietary and sporting supplements, eyewashes inhalers, cough or throat lozenges, etc.

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY DISCOMFORT, DIZZINESS, SWELLING, PAIN OR ANY OTHER REACTIONS AFTER TAKING ANY MEDICATION? PLEASE GIVE DETAILS OF WHEN THIS OCCURRED, TYPES OF MEDICATION, AND REACTIONS THAT YOU EXPERIENCED.