GOOD NATURED MEDICINE IN DEPTH PATIENT QUESTIONNAIRE

Name:	How did you hear about us?			
Allergies to medications or other substances:				
Address:	Da	ate of birth:	Height:	Weight:
Phone Number (day):	Occupatio	n (adult):		
Education:				
Marital Status (circle one): Single Married Partnered Divorced Wido	owed Separated	Number of Child	dren:	
Name of primary care physician or clinic:	Name(s) of mental health or other health care providers:			
IF CI	HILD, PARENTS O	R GUARDIANS NAI	ME(S):	
Mother/parent/guardian:		Father/parent/gu	ıardian:	
f parents are not living together, describe child	d's living situation	1:		
MAJOR HEALTH CONCERNS, IN ORD	ER OF IMPORTA	ANCE FOR YOU:	(USE ADDITIONAL PA	GES IF NECESSARY.
COMPLAINT	ONSET	& FREQUENCY	CAUSES (KNOV	VN OR SUSPECTED)
ARE YOU CURRENTLY TAKING ANY ME	DICATIONS OR HE	ERBS/SUPPLEMEN	TTS? (USE ADDITIONAL PA	AGES IF NECESSARY)
MEDICATION/SUPPLEMENT NAME	DATE START	TED & DOSAGE	REASON FOR TH	HIS MEDICATION
WHAT OTHER TREATMENTS, DIETS OR REC	HMES ARE YOU C	URRENTLY FOLL	OWING? (USE ADDITIONA	L PAGES IF NECESSAR'
TREATMENT OR REGIME		SINCE		RESULTS
		33.02		
Mi	EMBERS OF HOUS	EHOLD (INCLUDI	NG PETS)	
Name		AGE	RELATI	ONSHIP

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD? MARK P FOR PAST AND C FOR CURRENT.

Abscesses	Cancer	Gastric Reflux	Irritable Bowel Syndrome	Pneumonia	Trauma
Acne	Туре:	Gout	Kidney Disease	Post Traumatic Stress	Tuberculosis
Alcohol or drug abuse	Cataracts	Hay Fever	Liver Disease	Prostate condition	Typhoid Fever
Allergies	Chicken Pox	Headaches	Malaria	Psychiatric care	Ulcers
Addictions to:	Chronic cough	Heart Murmur	# of Mercury Fillings	Rheumatic fever	Last date of Urinary tract infection:
Anemia	Depression	Hepatitis	Memory problems	Sciatica	
Anxiety	Diabetes	Hernia	Measles	Sexual abuse	Recurrent vaginal infections
Appendicitis	Eating Disorder	Herpes	Migraines	Skin conditions	Whooping Cough
Arthritis	Emphysema	High Blood Pressure	Mononucleosis	Type:	Yeast infections
Asthma	Epilepsy	High Cholesterol	Mumps	STD's Specify:	Concerns for your personal safety?
Bleeding Disorders	Gall stones	HIV positive	Night Sweats since	Stroke or Cardiovascular event	War veteran?
Breast lump	Glaucoma	Hypoglycemia	Panic Attacks	Thyroid problems	Motor Vehicle Accident date:
Bronchitis	Goiter	Insomnia	Parasites	Tonsillitis	Weight problems

Any other major conditions?		
Are there any of the preceding con	nditions that were more severe than usual or yo	ou have not fully recovered from? Explain.
What operations/hospitalizations l	nave you had and when? Any complications?	
What major injuries have you had	and when? Any long-term effects?	
List any substances you are allerg	ic to and describe the reaction.	
What vaccinations have you had?	Any adverse effects?	
Do you have breast implants or ot	her foreign body parts (pacemaker)? Please lis	st date of implant.
If you're currently under the care	of another physician(s) please indicate treatme	ents you've received & for what condition:
What was the date of your last		
Physical exam?	GYN or PROSTATE exam?	Blood tests?

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT HAVE AFFECTED YOUR BLOOD RELATIVES:

Alcoholism	Bleeding	Disorders		Epil	epsy/Seizures	Kidney Disease		Schizophrenia
Allergies	Brain Tu	n Tumors		Gon	orrhea	Learning Disabiliti	ies	STDs ()
Anemia	Cancer ()	Gou		Mental Illness		Skin Conditions
Aneurysms	Cerebral				Fever	Mental Retardation	n	Stroke
Anxiety		l Dependen	cy		daches	Migraines		Syphilis
Arthritis	Depressi	on			rt Disease	Muscular Disease		Thyroid Disease
Asthma		(I or II	_)		atitis	Obsessive Compul		Tics
Bipolar Disorder	Eczema				h Blood Pressure	Paralysis		Tuberculosis
RELATIVE		AGE IF ALIVE	AGI DEA			MAJOR AILMENTS	S/CAUSE OF	DEATH
Mother								
Father								
Brothers								
Sisters								
Children								
Maternal Grandmot	her							
Maternal Grandfath	er							
Paternal Grandmoth								
Paternal Grandfathe								
Significant family d	eaths and	their age at	death,	descr	ibe any particular l	osses had a great imp	pact on you	or your family:
DIET / LIFESTYLE								
How many meals do you eat per day?								
Describe a typical day's diet. Include all meals, snacks and beverages and the times they are typically consumed.								
How much water do you drink per day? Do you tend to be thirsty?								
Other beverages? Describe.								
Do you prefer hot, cold or room temperature beverages?								
What foods do you avoid?								
List symptoms caused by any particular foods or drinks.								
List the foods you crave, regardless of their nutritional value (ex: sweets, chocolate, salty, sour, breads, rich/fatty, spicy, hot, cold, bitter):								
How often do you have bowel movements per week? Do you see any undigested food/blood/mucous in stool?								
			_			elching/Gas?		
How much of the following substances are you using regularly:								
Tobacco:	Alco		c you	_	Coffee:	Recreational	Drugs:	

Have you lost or gained any weight in the last six months?	How many pounds?	By what method?
What exercise do you do?	Length of time?	Frequency?
What type of weather do you like and dislike? (temperate, me	ountain, seashore, desert)	
What things give you the most pleasure in life? Describe.		
What things give you the most displeasure? Describe.		
List any fears and phobias you may have: (claustrophobia, da	ark, thunderstorms, animal	s, water, heights, etc)
How is your sleep? What t	ime do you go to bed?	
Do you have trouble falling asleep? What k	teeps you up?	
Do you wake in the night? What t	ime(s) is/are typical?	
What time do you wake in the morning? Do you	wake feeling refreshed?	
What position do you sleep in? Is there	e a position you cannot sle	ep in?
Do you stay covered at night? Do you	ı stick your feet out from u	under the covers?
What is your sense of your body temperature? Warm/cold	Your hands? Warm/co	old Your Feet? Warm/cold
When you are upset do you like to be consoled & how?	Do you like to be	around other people?
List any characteristic dreams you have now or had in th important to you.	e past. Include dreams w	which are/were vivid, recurrent or seemed
What is the best time of day for you & why?		
What is the worst time of day for you & why?		
Are there any unique or peculiar patterns to your symptoms of	or life in general?	

OPTIONAL CHRONOLOGICAL TIMELINE (USE ADDITIONAL PAGES IF NECESSARY)

While not always apparent, your state of mental & physical health is influenced by, and influences, your life events. Jot down the timing of your main health concerns (from page 1), then, fill in the other column with what was of primary importance in your life at the time. Consider, for example, the following:

- Significant and recurrent illnesses
- Traumas and injuries, either physical or emotional
- Developmental and life milestones
- Medications used; surgeries; substance abuse

- Specific strong memories
- Important dates (e.g., moves, family stress, relationship changes, births, deaths, pets, etc.)

Age (or Year)	Change in Physical or Emotional Health	Life Events & Primary Goals