# Adult Healthy Living Consult Questionnaire

**PATIENT INFORMATION** **Allergies:** _____ **Weight:** _____ **Date:** _____

| | | |
|---|---|---|
| **Patient Information** | *First Name* | *Email Address:* |
| | *Middle Name* | *Phone Number:* |
| | *Last Name* | |
| | *Street Address* | *Apt* |
| | *City* | *State* |
| | *Zip Code* | *Date of Birth* *Age* *Height* |

**REFERRED BY**

_____

**CURRENT/ON-GOING PROBLEMS**

**Why are you coming in for help at this particular time?** _____

_____

_____

_____

_____

**Please List all current and ongoing problems and diagnoses in order of priority:**

| *Describe Problem* | *Mild* | *Moderate* | *Severe* | *Prior Treatment/Approach* | *Excellent* | *Good* | *Fair* |
|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ |

**When did you first notice problems?** _____

_____

_____

_____

_____

**FOOD HISTORY**

| | |
|---|---|
| **Typical Breakfast** | |
| **Typical Lunch** | |
| **Typical Dinner** | |
| **Snacks** | |
| **Favorite Foods** | |
| **Food Intolerances** | |

## Adult Healthy Living Consult Questionnaire

### GENERAL QUESTIONS

**Please describe your current job or class schedule?**

_____
_____
_____

**What do you do for exercise?**

*Please describe:* _____
_____
_____

**What kind of activities and hobbies do you enjoy?**

*Please describe:* _____
_____
_____

**Who do you live with?**

*Please describe:* _____
_____
_____

**Is there stress in your current living situation?** ☐ *Yes* ☐ *No*

*If yes please describe:* _____
_____
_____

**Do you feel stressed otherwise?** ☐ *Yes* ☐ *No*

*If yes please describe:* _____
_____
_____
_____

**Have you experienced any major life changes or losses that may have impacted your health?** ☐ *Yes* ☐ *No*

*If yes please describe:* _____
_____
_____
_____

**Have you ever sought counseling for yourself?** ☐ *Yes* ☐ *No*

*If yes please describe:* _____
_____
_____
_____

**Have you ever been abused or been a victim of crime?** ☐ *Yes* ☐ *No*

*If yes please describe:* _____
_____
_____
_____

| | |
|---|---|
| **Do you currently use illicit drugs?** | ☐ *Yes* ☐ *No* |
| *If yes please describe:* _____ | |
| **Have you previously used illicit drugs?** | ☐ *Yes* ☐ *No* |
| *If yes please describe:* _____ | |
| **Do you snore or have sleep apnea?** | ☐ *Yes* ☐ *No* |
| *If yes please describe:* _____ | |
| **How many hours do you sleep per night?** | |
| **Do you sleep well?** | ☐ *Yes* ☐ *No* |
| *If no please describe:* _____ | |
| **Do you get along well with friends and family members?** | ☐ *Yes* ☐ *No* |
| *If no please describe:* _____ | |

## MEDICAL HISTORY

**Under/Over Methylation** *Please check any boxes that apply.*

| Under Methylation | | Over Methylation | |
|---|---|---|---|
| ☐ | Seasonal Allergies | ☐ | Chemical and Food Sensitivities |
| ☐ | Perfectionism | ☐ | Under-achiever |
| ☐ | Competitiveness | ☐ | Upper Body Pain |
| ☐ | Obsessive-Compulsive Tendencies | ☐ | Adverse Reaction to SSRI Medication (Prozac, Paxil, Zoloft, St. John's Wort) |
| ☐ | Highly Motivated | ☐ | Dry Eyes |
| | | ☐ | Self-Injury |
| | | ☐ | High Artistic/Musical Ability |

**Adult Healthy Living Consult Questionnaire**

**Left Brian/Right Brain Characteristics** *Please check any boxes that apply.*

| Right Brain | | Left Brain | |
|---|---|---|---|
| ☐ | Visual | ☐ | Demonstrates Logical Thinking |
| ☐ | Spontaneous | ☐ | Good with Detail |
| ☐ | Likes to be Shown how to do a Task Rather then be Told | ☐ | Memorizes Easily |
| ☐ | Solves Problems by Looking at Similarities and Patterns Rather than Differences | ☐ | Good at Math |
| ☐ | Would Rather Draw than Write | ☐ | Thinks in Words |
| ☐ | Thinks in Pictures | ☐ | Assimilates Information by Looking at the Pieces before Looking at the Whole |
| ☐ | Assimilates Whole Chunks of Information before Breaking Down the Information into Discrete Pieces | ☐ | Solves problems by Looking at Differences Rather than Similarities |

| **Pyroluria** – Please check any boxes that apply. | | | |
|---|---|---|---|
| ☐ | Poor Stress Control | ☐ | Poor Short Term Memory |
| ☐ | Fearfulness | ☐ | Sensitivity to Loud Noises |
| ☐ | Sensitivity to Bright Lights | ☐ | Like Spicy and Salty Foods |
| ☐ | Morning Nausea | ☐ | Pale Skin/Inability to Tan |
| ☐ | Tendency to Skip Breakfast | ☐ | Has Delicate Facial Features |
| ☐ | High Irritability and Temper | ☐ | Extreme Mood Swings |
| ☐ | History of Under Achievement | ☐ | Severe Inner Tension |
| ☐ | Little or No Dream Recall | ☐ | Poor Muscle Development |
| ☐ | Auto Immune Disorders | ☐ | Delayed Growth |
| ☐ | Delayed Puberty | ☐ | Fruity Breath and/or Body Odor |
| ☐ | Frequent Infections | ☐ | Tendency to Stay Up Very Late |
| ☐ | Mauve or Dark Colored Urine | ☐ | History of a Reading Disorder |

| **Blood Type** – Please check applicable box. | | | |
|---|---|---|---|
| ☐ | A | ☐ | B |
| ☐ | AB | ☐ | O |
| ☐ | Don't Know | | |

## Adult Healthy Living Consult Questionnaire

**PREVIOUS EVALUATIONS** check box if yes and provide year

| | | | | | |
|---|---|---|---|---|---|
| ☐ | | Full Physical Exam | ☐ | | Psychological Evaluations |
| ☐ | | WPPSI or WISC-R for Intelligence | ☐ | | Speech and Language Evaluations |
| ☐ | | Genetic Evaluation | ☐ | | Neurological Evaluations |
| ☐ | | Gastroenterology Evaluations | ☐ | | Other Injuries |
| ☐ | | Celiac/Gluten Testing | ☐ | | Auditory Evaluation |
| ☐ | | Allergy Evaluation | ☐ | | Vision Testing |
| ☐ | | Nutritional Evaluation | ☐ | | Labs (Please provide copies of results) |
| ☐ | | X-rays or Scans | | | |

**HOSPITALIZATIONS/INJURIES/SURGERIES**

| Date | Describe |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Adult Healthy Living Consult Questionnaire

**DISEASES/DIAGNOSIS/CONDITIONS** *Check appropriate box and provide date of onset for any of these conditions if applicable.*

| | Date | GASTROINTESTINAL |
|---|---|---|
| ☐ | | Irritable Bowel Syndrome |
| ☐ | | Inflammatory Bowel Disease |
| ☐ | | Crohn's |
| ☐ | | Ulcerative Colitis |
| ☐ | | GERD (reflux) |
| ☐ | | Celiac Disease |
| ☐ | | Chronic Diarrhea |
| ☐ | | Chronic Constipation |
| | | **CARIOVASCULAR** |
| ☐ | | Heart Disease |
| ☐ | | Elevated Cholesterol |
| ☐ | | Other |
| | | **METABOLIC/ENDOCRINE** |
| ☐ | | Type 1 Diabetes |
| ☐ | | Type 2 Diabetes |
| ☐ | | Metabolic Syndrome |
| ☐ | | Hypothyroidism (low thyroid) |
| ☐ | | Hyperthyroidism (overactive thyroid) |
| ☐ | | Weight Gain |
| ☐ | | Weight Loss |
| ☐ | | Bulimia |
| ☐ | | Anorexia |
| ☐ | | Eating Disorder (Non-specific) |
| ☐ | | Other |
| | | **CANCER** |
| ☐ | | |

| | | NEUROLOGIC/MOOD |
|---|---|---|
| ☐ | | Depression |
| ☐ | | Anxiety |
| ☐ | | Bipolar Disorder |
| ☐ | | Schizophrenia |
| ☐ | | Migraines |
| ☐ | | Seizures |

| | Date | GENTIAL AND URINARY SYSTEMS |
|---|---|---|
| ☐ | | Urinary Tract Infections |
| ☐ | | Yeast Infections |
| | | **MUSCULOSKELETAL/PAIN** |
| ☐ | | Arthritis |
| ☐ | | Chronic Pain |
| ☐ | | Other |
| | | **INFLAMMATORY/AUTOIMMUNE** |
| ☐ | | Autoimmune Disease |
| ☐ | | Poor Immune Function |
| ☐ | | Food Allergies |
| ☐ | | Environmental Allergies |
| ☐ | | Multiple Chemical Sensitivities |
| ☐ | | Latex Allergy |
| ☐ | | Repeat or Recurrent Strep Throat |
| ☐ | | Other |
| | | **RESPIRATORY DISEASES** |
| ☐ | | Frequent Ear Infections |
| ☐ | | Frequent Upper Respiratory Infections |
| ☐ | | Asthma |
| ☐ | | Chronic Sinusitis |
| ☐ | | Bronchitis |
| ☐ | | Sleep Apnea |
| ☐ | | Other |
| | | **SKIN DISEASES** |
| ☐ | | Eczema |
| ☐ | | Psoriasis |
| ☐ | | Acne |
| ☐ | | Other |
| | | **NEUROLOGIC/MOOD** |
| ☐ | | Sensory Integrative Disorder |
| ☐ | | Autism |
| ☐ | | Mild Cognitive Impairment |
| ☐ | | Headaches |
| ☐ | | ADD/ADHD |
| ☐ | | Other Neurological Problems |

## FAMILY HISTORY

**List all psychological and medical conditions that run in the patient's family:**

| Family Member | Current Conditions | Past Conditions |
|---|---|---|
| **Mother** | | |
| **Father** | | |
| **Siblings** | | |
| **Other** | | |

**Who do you live with?** _____

## TRAVEL HISTORY

**Have you traveled to foreign countries?** ☐ Yes ☐ No **Where?** _____

_____

**Any wilderness camping?** ☐ Yes ☐ No **Where?** _____

_____

**Ever had:** ☐ Gastroenteritis ☐ Diarrhea **Describe:** _____

_____

## DENTAL HISTORY

**Fillings?:** ☐ Yes ☐ No **What kind?** _____

**Other Dental Problems:** ☐ Yes ☐ No **If so, please describe:** _____

_____

**Regular Dental Visits?:** ☐ Yes ☐ No

## MEDICATIONS

### CURRENT MEDICATIONS

| Medication | Dose | Frequency | Start Date (mo/yr) | Reason for Use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

### PREVIOUS MEDICATIONS *(Last 10 Years)*

| Medication | Dose | Frequency | Start Date (mo/yr) | Reason for Use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

### NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

| Supplement and Brand | Dose | Frequency | Start Date (mo/yr) | Reason for Use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Have medications or supplements ever caused any unusual side effects or problems:** □ Yes □ No **If so, please describe:** _____

_____

**Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?** □ Yes □ No **If so please describe:** _____

_____

**Have you had prolonged or regular use of Tylenol?** □ Yes □ No

**Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.), Motrin, Aspirin?** □ Yes □ No **If so please describe:** _____

_____

**Frequent antibiotics > 3 time/year?** □ Yes □ No
**Long term antibiotics?** □ Yes □ No
**Use of steroids (prednisone, nasal allergy inhalers) in the past?** □ **Yes** □ **No**

## GYNECOLOGIC HISTORY *(For Older Females Only)*

Age at first Period: _____ Menses Frequency: _____ Length: _____
Pain: □ Yes □ No Has your period ever skipped?: _____ For how long: _____
Last Menstrual Period: _____ Use contraception? □ Yes □ No If yes, please describe: _____

_____

Are you pregnant? □ Yes □ No
Do you plan on becoming pregnant soon? □ Yes □ No

## ANYTHING ELSE

**Is there anything else that you would like me to know?** _____

_____

_____

_____

_____