**Heartstone Pure Health Consulting**

**Louise Bakley, DMH DHHP**

**Heilkunst New Patient Questionnaire**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_

**Address:**

**Phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_ \_

What is your chief complaint (please name ailments), and then describe your symptoms.

When did you first have this/these complaints, even in a very mild form?

**Dietary Habits:**

Do you follow any particular diet? (e.g. SCD, Gluten Free, GAPS, Paleo)

Do you have any known food allergies or sensitivities?

How would you describe your appetite?

What percentage of your meals are home-cooked?

 Please share what a typical daily diet looks like.

**Breakfast**:

Do you eat breakfast every day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lunch**:

**Dinner**:

**Snacks:**

Are there any foods that you avoid because of the way they make you feel?

If yes, please explain the food, and the symptom(s)

 Do you have symptoms immediately after eating like bloating, gas, sneezing or hives? If so, please explain.

 Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc?

Are there any particular foods that you crave throughout the day?

When do you usually feel these cravings?

Is there anything else I should know about your current diet, history or relationship with food?

**Hydration:**

How much water do you drink?

Do you drink tap or filtered water?

How much coffee/tea do you drink?

If you drink coffee/tea is it caffeinated or decaffeinated?

How much juice do you drink (commercial juices)

How much milk do you drink? And what kind?

How often do you drink alcoholic beverages?

**Sleep:**

What time do you generally go to bed each night? Wake up in the morning?

Do you fall asleep easily?

Do you wake up with/without an alarm?

Do you wake up feeling rested or tired?

Do you wake up through the night? If so is there a consistent time you wake up each night??

Do you have more energy in the morning or the evening?

**Intestinal Status:**

Bowel movement frequency

\_\_\_ 1-3 times per day

\_\_\_ More than 3 times per day

\_\_\_ Not regularly every day

Bowel Movement Consistency:

\_\_\_ soft and well formed

\_\_\_ often float

\_\_\_ difficult to pass

\_\_\_ diarrhea

\_\_\_ thin, long or narrow

\_\_\_ small and hard

\_\_\_ loose but not watery

\_\_\_ alternating between hard and loose

Bowel Movement Color

\_\_\_ medium brown

\_\_\_ very dark or black

\_\_\_ greenish

\_\_\_ blood is visible

\_\_\_ variable

\_\_\_ yellow, light brown

\_\_\_ chalky colored

\_\_\_ Greasy, shiny

Do you experience intestinal gas: If so, please explain if it is excessive, occasional, odorous etc.

 **Energy Level**

How is your energy throughout the day?

Do you feel peaks and valleys? If so when do they generally occur?

On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy?

 **Recreation**

Would you describe yourself as generally active or sedentary?

Are there typical activities that you enjoy? (walking, running yoga etc)

Do you enjoy and participate in any particular sports?

Are there any particular activities that you do just for fun?( hobbies)

**Work**

What type of work do you do?

Do you enjoy work or is it stressful?

 Stress

How would you describe the stress in your life?

What, if any, do you do to reduce or relieve stress?

 **Mental Health Status**:

How are your moods in general? Do you experience more than you would like of anxiety? Depression? Anger?

 At what point in your life did you feel best? Why?

**Current Medical/Health Concerns:** allergies, digestive issues, skin, lung, recurrent infections, physical pains, behavior issues etc.

Number of surgeries:\_\_\_\_\_\_\_\_\_\_

Metal Amalgam Fillings:\_\_\_\_\_\_\_\_

 **Drugs/herbal supplements**

Do you take any prescription/ herbal drugs? \_\_\_\_\_\_\_ and if so what and why and for how long?

 What, if any, dietary supplements do you take?

Do you smoke tobacco?

Do you take any recreational drugs?

 Family History

 Please indicate which family members have had, or currently have the following conditions.

|  |  |  |  |
| --- | --- | --- | --- |
| Condition |   | Condition |   |
| Alcoholism |   | Cancer |   |
| Allergies |   | Cataracts |   |
| Arteriosclerosis |   | Celiac Disease |   |
| Arthritis |   | Crohn's/Colitis |   |
| Asthma |   | Depression |   |
| Bed Wetting |   | Diabetes |   |
| Birth Defects |   | Epilepsy |   |
| Blindness |   | Osteoporosis |   |
| Heart Disease |   | Ulcers |   |
| Hyperactivity |   | Stroke |   |
| Kidney Disease |   | TB |   |
| Learning Disability |   | Yeast Infections |   |
| Mental Illness |   |   |   |
| MS |   |   |   |
| MD |   |   |   |

Have you or your child received the following vaccinations? Please check those that apply.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Type | 2 months | 4 months | 6 months | 18 months | 4-6year | 14-16years | Boosters |   |
| Diphtheria |   |   |   |   |   |   |   |   |
| Pertussis |   |   |   |   |   |   |   |   |
| Tetanus |   |   |   |   |   |   |   |   |
| Polio (IPV) |   |   |   |   |   |   |   |   |
| Polio (OPV) |   |   |   |   |   |   |   |   |
| Hib |   |   |   |   |   |   |   |   |
| Measles |   |   |   |   |   |   |   |   |
| Rubella |   |   |   |   |   |   |   |   |
| Hepatitis B |   |   |   |   |   |   |   |   |
| Chicken Pox |   |   |   |   |   |   |   |   |
| Meningitis |   |   |   |   |   |   |   |   |
| Influenza |   |   |   |   |   |   |   |   |
| Hepatitis A |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |

Please note any reactions to immunizations:

Please list any treatments and/or medications you have used from the present to the past in reverse chronological order with approximate dates. Please include prescriptions, over the counter and recreational, vaccinations, and medical treatments such as MRI’s, X-rays, surgery, dental procedures etc. Please include any exposure to environmental toxins, such as pesticides, paints etc. It is important to consider emotional events in your life as well. The more detailed you can make this, the more useful this information is in helping guide your practitioner in treatment.

Date: (from Present to Past) Medications/Vaccinations/Treatments/Emotional Trauma

Is there any additional information you would like to share?

Client Agreement

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree that my progress and wellness goals are dependent upon me taking responsibility to follow the recommended protocol as set out by my practitioner. I understand that this may require me to modify my regimen including my diet and sleep patterns, and I agree that I am willing to make a concerted effort to make the necessary modifications to achieve optimal wellness. I understand that reversal of disease is a process and that it takes time and determination to achieve optimal wellness. I agree to keep my regularly scheduled appointments in order to optimize my desired state of health, wellbeing and success.

Signature of patient/Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_