Print Form

Date of Service:

Place of Service:

Location of Service:

Preliminary Questionnaire For Potential New Adult Patient

Our practice asks that you fill out this brief questionnaire before we schedule an appointment with our office. The purpose of this questionnaire is to determine if there is a good fit between your needs and our practice, and to determine starting points from which to give you more detailed intake materials to fill out.

If after reviewing your responses on this form we determine our practice is likely to be able to help the patient (Pt) you describe here, we will provide you with possible appointment times and also send you a lengthier/more involved historical questionnaire to complete before that appointment. Otherwise, we will provide you with referrals, if possible, to other practitioners.

Please understand that neither the completion of this brief questionnaire nor the practitioner reviewing it prior to the patient's face-to-face appointment will establish a practitioner-patient relationship. **If the patient has severe or potentially life-threatening physical or emotional situations arise while waiting for an appointment in this practice, the patient should go to a hospital emergency department or at least immediately communicate with their primary care physician.** Please do not contact our office as we will not be able to provide any advice or care until your first in-person appointment.

Background:

Pt's First Name: Middle Name: Last Name:

Birth Date: Age: Sex:

Residence, Street No: Street Name: City:

State: Zip: Country:

Email

Cell Phone

Home Phone

Referred by:

- Family/Friends
- Other Physician/Therapist
- Support group, including online group
- Website
- Newspaper article/interview
- Magazine article/interview
- Internet search
- Internet article/interview
- Radio or TV interview/presentation
- Conference/webinar presentation
- Other

1) Concisely, what do you hope to achieve overall from your treatment in this practice?

2) Chief Complaints/Concerns

a) Please list/describe, in order of priority, the top 3-5 concerns/symptoms/challenges of the patient.

1)

2)

3)

4)

5)

b) Are there any specific types of treatments that you hope to incorporate in your child's treatment:

c) Please list and briefly describe any previous integrative/holistic approaches that you already used to help your child (i.e. herbal therapies, homeopathy, etc.)

3) Height (ft and in):

Present Weight (lbs):

4) Readiness assessment - Rate by choosing on a scale from 5 (very willing) to 1 (not willing)

a) In order to achieve your health goals, how willing are you to:

i) Improve/change your diet and drink enough water each day? ☐5 ☐4 ☐3 ☐2 ☐1

ii) Take nutritional supplements two to three times a day? ☐5 ☐4 ☐3 ☐2 ☐1

iii) Modify your lifestyle (i.e. sleep, exercise, relaxation)? ☐5 ☐4 ☐3 ☐2 ☐1

iv) Do lab testing (collecting urine &/or stool & going for a blood draw?) ☐5 ☐4 ☐3 ☐2 ☐1

b) How supportive are those closest to you in assisting/helping you make changes? ☐5 ☐4 ☐3 ☐2 ☐1

c) Would anyone close to you be an obstacle to you as you are getting well? ☐Yes ☐No

d) How certain/confident are you in your ability to make changes in diet, water consumption, exercise, supplements, lifestyle? ☐5 ☐4 ☐3 ☐2 ☐1

e) If you are not very confident in your ability to make necessary changes or to get the help you need to make changes, what obstacles do you foresee?

5) Do you speak English? ☐Yes ☐No

If the patient or family does not speak English, you will be required to bring a medical translator to all appointments.

Will you have an interpreter available for all consultations and phone calls? ☐Yes ☐No

6) If the patient is a disabled adult, can you provide documentation of power-of-attorney/guardian for medical decisions? ☐Yes ☐No

Who is POA?

7) Are you pregnant or are you planning to get pregnant any time in the next year? ☐Yes ☐No ☐N/A

8) Are you breastfeeding now? ☐Yes ☐No ☐N/A

If yes, how many more months do you plan to continue?

9) Do you have a history of any of the following in the last year? Describe beside each "Yes".

Cancer	☐Yes ☐No	
Heart Disease	☐Yes ☐No	
Stroke	☐Yes ☐No	
Severe Dementia	☐Yes ☐No	
Poorly-controlled Diabetes	☐Yes ☐No	
Kidney Failure	☐Yes ☐No	
Servere Lung Disease	☐Yes ☐No	

10) Have you had any of the following recently (in the last 2 months) or in the past (>2mo.)?

Indicate "R" for recent, "P" for past or check both if both apply.

Thoughts of harming yourself	☐No ☐R ☐P
Suicide attempts	☐No ☐R ☐P
Thoughts of harming others	☐No ☐R ☐P
Self-injurious behaviors (cutting, burning, etc.)	☐No ☐R ☐P
Rage attacks	☐No ☐R ☐P
Alcohol abuse or dependence	☐No ☐R ☐P
Recreational drug use	☐No ☐R ☐P
Psychosis	☐No ☐R ☐P
Periods of mania	☐No ☐R ☐P
Eating disorder (purging, laxatives, etc.)	☐No ☐R ☐P

If you mark "Recent" or "Past" to any of the questions in section 8, please comment further below. Include dates that you experienced symptoms and treatments. Please also indicate if you are currently under the care of a psychologist or psychiatrist. Feel free to provide additional information below.