Patient Comprehensive Assessment Questionnaire

Name: _____Date: _____ Age:_____ Sex: _____ Height: _____Weight: _____

PART I - Health Priorities

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II - Symptom Survey

Please mark the appropriate box on all questions below ***based on your health in the past year****.*

	Never	Sometimes	Always
Feeling that bowels do not empty completely	□	□	□
Lower abdominal pain or discomfort following meals	□	□	□
Sense of fullness during and after meals	□	□	□
Diarrhea, urgent, loose, watery stools	□	□	□
More than 3 bowel movements daily	□	□	□
Constipation, dry, hard, infrequent stools	□	□	□
Use of laxatives	□	□	□
Stools are foul smelling	□	□	□
Stools are mucous-like, greasy, or poorly formed	□	□	□
Undigested foods found in stools	□	□	□
Pass large amount of foul-smelling gas	□	□	□
Excessive belching, burping, or bloating	□	□	□
Heartburn	□	□	□
Stomach pain, burning or aching 1-4 hours after eating	□	□	□
Use of antacids	□	□	□
Pain, tenderness, soreness on left side under rib cage	□	□	□
Greasy or high fat foods cause nausea or discomfort	□	□	□
Nausea and/or vomiting	□	□	□
Certain foods cause sinus congestion, headaches	□	□	□
Offensive breath	□	□	□
Bitter metallic taste in mouth, especially in the morning	□	□	□
Asthma or difficulty breathing	□	□	□
Frequent colds or recurrent infections	□	□	□
Frequent urination	□	□	□
Urinary tract infection	□	□	□
Increased thirst and appetite	□	□	□
Unexplained itchy skin	□	□	□

	Never	Sometimes	Always
Eczema, psoriasis, recurrent rashes	□	□	□
Dry or flaky skin and/or hair	□	□	□
Thinning of hair on scalp, face, or genitals	□	□	□
Weak nails	□	□	□
Outer third of eyebrow thins	□	□	□
Gallbladder attacks or stones	□	□	□
Have you had your gallbladder removed?	Yes	No	
Crave sweets during the day	□	□	□
Eating sweets does not relieve cravings for sugar	□	□	□
Must have sweets after meals	□	□	□
If meals are missed feel irritable, lightheaded or shaky	□	□	□
Slow starter in the morning	□	□	□
Depend on coffee to keep yourself going or started	□	□	□
Poor memory, forgetful, mental sluggishness	□	□	□
Cannot fall asleep, insomnia	□	□	□
Cannot stay asleep	□	□	□
Wake up tired even after 6 or more hours of sleep	□	□	□
Require excessive amounts of sleep to function properly	□	□	□
Crave salt	□	□	□
Dizziness when standing up quickly	□	□	□
Headaches	□	□	□
Migraines	□	□	□
Excessive perspiration or with little or no activity	□	□	□
General fatigue, tired, sluggish most of day	□	□	□
Fatigue after meals	□	□	□
Afternoon fatigue	□	□	□
Feel cold - hands, feel, all over	□	□	□
Depression, lack of motivation	□	□	□
Heart palpations, increased pulse at rest	□	□	□
Nervousness or anxious	□	□	□
Night sweats	□	□	□
Difficulty gaining weight	□	□	□
Difficulty losing weight	□	□	□
Diminished sex drive	□	□	□
Increased sex drive	□	□	□

	Never	Sometimes	Always
Urination difficulty or dribbling	□	□	□
Pain inside of legs or heels	□	□	□
Leg nervousness at night, restless leg	□	□	□
Inability to concentrate or stay focused	□	□	□
Muscle soreness, stiffness, achy joints	□	□	□
Decrease in physical stamina	□	□	□
Increase in fat distribution around abdomen and hips	□	□	□

For Women:

Menstrual disorders or lack of menstruation	□	□	□
Are you experiencing menopause	Yes		No
Extended menstrual cycle (greater than 32 days)	Yes		No
Shortened menses (less than every 24 days)	Yes		No
Pain and cramping during periods	□	□	□
Scanty blood flow	□	□	□
Heavy blood flow	□	□	□
Breast pain and swelling during menses	□	□	□
Irritable and depressed during menses	□	□	□
Acne breakouts	□	□	□
Facial hair growth	□	□	□

How many years have you been post-menopausal? _____

Do you ever have uterine bleeding since menopause?	Yes	No
Hot flashes	□ □	□
Mood swings	□ □	□
Painful intercourse	□ □	□
Increased vaginal, pain, dryness, or itching	□ □	□

For Men:

Decrease in spontaneous morning erections	□	□	□
Decrease in fullness of erections	□	□	□

Other:

Please list any conditions or symptoms not listed above:

_____

_____

PART III - Lifestyle

How many alcoholic beverages do you consume per week? ____

How many caffeinated beverages do you consume per day?____

How many times do you eat out per week?_____

Do you exercise? _____ If yes, how often and what type(s)?

_____

_____

_____

List the three worst foods you eat during the average week:

1. _____
2. _____
3. _____

List the three healthiest foods you eat during the average week:

1. _____
2. _____
3. _____

Do you smoke?_____ If yes, how many times a day _____

Rate your stress levels on a scale of 1-10 during the average week *(1 as the least stress to 10 as the most stress)* _____

Please list any medications you currently take and the conditions you take them for: _____

_____

_____

_____

_____

Please list any natural supplements you currently take and the conditions you take them for:_____

_____

_____

_____

_____

How many times a day do you eat? _____

What do you usually eat for:

Breakfast? _____

_____

_____

_____

Lunch?_____

_____

_____

_____

Dinner? _____

_____

_____

_____

Snacks?_____

_____

_____

_____