BackBone
WELLNESS CENTER

12101 W. Parmer Lane Ste. 200
Cedar Park, Texas 78613
Phone: 512.363.5178
Fax: 512.339.2664

ADULT MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Appointment date: _____

Name Mr. / Mrs. / Ms. / Dr. _____

Address _____
Street City State Zip Code

Social Security # _____ Sex: Male / Female

Birth date _____ Age _____ Marital Status: Married / Single

Height: ____' ____" Weight:_____

Home # ( ) _____ Work # ( ) _____ Cell # ( ) _____

E-Mail Address _____@_____

Preferred Method of Contact: ☐ E-Mail ☐ Postal Mail ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Would you like to receive our eNewsletter? Yes No

Employer _____ Occupation _____

Job Functions/Work Environment _____

Referred by:
☐ Physician / Clinician (name, contact) _____
☐ Book ☐ Website ☐ Media ☐ Friend / Family Member ☐ Other _____

Physician:

Name _____

Phone Number _____ Fax _____

Please List all Allergies:

☐ Animal Dander	☐ Latex	☐ Penicillin	☐ Pollen	☐ Second-Hand Smoke
☐ Grasses	☐ Hay	☐ Sulfa Drugs	☐ Perfumes	☐ Dairy Products
☐ Food Allergies:_____			☐ Other: _____	

What do you hope to achieve with your visit today?

When was the last time you felt well?

What caused the change in your health?

What makes you feel worse?

What makes you feel better?

If you could erase three problems, what would they be?

1. Please check appropriate box(es):

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European ☐ Other

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.) Example: Wendy, age 7, sister.

_____

_____

4. Have you lived or traveled outside of the United States? ☐ Yes ☐ No

   If Yes, when and where?

5. What city and state did you grow up in? _____ ☐ Rural ☐ Industrial

6. Have you or your family recently experienced any major life changes? ☐ Yes ☐ No

   If yes, please comment: _____

7. Have you experienced any major losses in life? ☐ Yes ☐ No

   If yes, please comment: _____

8. Past Medical and Surgical History (continues on the following page):

	ILLNESSES	WHEN	COMMENTS
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn's Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		
	ILLNESSES	**WHEN**	**COMMENTS**
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		
	INJURIES	**WHEN**	**COMMENTS**
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		

aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Other (describe)		
	OPERATIONS	**WHEN**	**COMMENTS**
au.	Appendectomy		
av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

9. Hospitalizations:

WHERE HOSPITALIZED	**WHEN**	**FOR WHAT REASON**
a.		
b.		
c.		
d.		
e.		

10. Family Medical History (continues on the following page)

DISEASE	**RELATIVE(S) AFFECTED**
Alzheimer's	
Allergies	
Anemia	
Arthritis	
Asthma	
Bleeding Problems	
Cancer	
Depression	
Diabetes	

Eye Disease	
Heart Disease	
High Cholesterol	
High Blood Pressure	
Kidney Disease	
Migraine Headache	
Osteoarthritis	
Osteoporosis	
Stroke	
Thyroid Disorders	
TB	
Ulcers	
Other	

11. How often have you taken antibiotics?

	< 5 Times	> 5 Times
Infancy/Childhood		
Teen		
Adulthood		

12. How often have you had to take oral steroids (e.g. Cortisone, Prednisone, etc.)?

	< 5 Times	> 5 Times
Infancy/Childhood		
Teen		
Adulthood		

13. What medications are you taking now? Include non-prescription drugs.

Medication Name	**Date started**	**Dosage**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

14. Are you allergic to any medications? Yes____ No____

If yes, please list: _____

_____

15. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	**Date started**	**Dosage**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

16. Childhood: Were you a full term baby? Yes____ No____ Don't Know _____ Comments: _____

    Premature? Yes____ No____ Don't Know _____ Comments: _____

    Breast fed? Yes____ No____ Don't Know _____ Comments: _____

    Bottle fed? Yes____ No____ Don't Know _____ Comments: _____

17. As a child, did you eat a lot of sugar and/or candy? Yes____ No____

18. As a child, were there any foods that you had to avoid because they gave you symptoms? Yes____ No____

    If Yes, please name the food(s) and symptom(s): _____

    _____

19. Have you ever used alcohol? Yes____ No____

20. Have you ever had a problem with alcohol? Yes____ No____
    If yes, please indicate time period (month/year): from _____ to _____.

21. Have you ever used recreational drugs? Yes____ No____

22. Have you ever used tobacco? Yes____ No____
    If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
    If yes, what type of nicotine have you used? _____Cigarette _____ Smokeless
    _____Cigar _____Pipe _____Patch/Gum
    What kind? _____

    Comments: _____

23. Are you exposed to second-hand smoke regularly? Yes____ No____
24. Do you have mercury amalgam fillings? Yes____ No____
25. Do you have artificial joints or implants? Yes____ No____
26. Do you feel worse at certain times of the year? Spring____ Summer____ Fall____ Winter ____ No____
27. Have you, to your knowledge, been exposed to any of the following toxic metals? Yes____ No____
28. If yes, which one(s)? ____ lead ____cadmium ____ aluminum
    ____ arsenic ____ mercury

29. Do odors affect you? Yes____ No____

30. Do you exercise regularly? Yes____ No____
If so, how many times a week? _____ When you exercise, how long is each session? _____

31. Any other family history we should know about? Yes____ No____

If so, please comment: _____

32. What is the attitude of those close to you about your illness? _____Supportive _____Non-supportive

33. Place a check mark next to the food / drink that applies to your current diet.

	Usual Breakfast	✓		**Usual Lunch**	✓		**Usual Dinner**	✓
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans / Legumes	
c.	Bagel		c.	Coffee		c.	Brown Rice	
d.	Butter		d.	Eat in Cafeteria		d.	Butter	
e.	Cereal		e.	Eat in Restaurant		e.	Carrots	
f.	Coffee		f.	Fish		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green Vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat		l.	Pasta	
m.	Oat Bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
o.	Sweet Roll		o.	Salad Dressing		o.	Red Meat	
p.	Sweetener		p.	Sandwich		p.	Salad	
q.	Tea		q.	Soda		q.	Salad Dressing	
r.	Toast		r.	Soup		r.	Soda	
s.	Water		s.	Sugar		s.	Sugar	
t.	Wheat Bun		t.	Sweetener		t.	Sweetener	
u.	Yogurt		u.	Tea		u.	Tea	
v.	Other (List below)		v.	Tomato		v.	Water	
			w.	Water		w.	White Rice	
			x.	Yogurt		x.	Yellow Vegetables	
			y.	Other (List below)		y.	Other (List below)	

34. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee with sugar	
e.	Cups of decaf coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of caffeinated tea	
h.	Diet soda	
i.	Ice cream	
j.	Salty food	
k.	Slices of white bread, rolls, bagels	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

35. Are you on a special diet? Yes____ No____
_____ ovo-lacto _____ vegetarian _____ diabetic _____ blood type
_____ diabetic _____ vegan _____ dairy restricted
_____ other (describe): _____

36. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain: _____

37. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
Yes____ No____

If yes, are these symptoms associate with any particular food(s) or supplement(s)? Yes____ No____

If yes, please list the food(s) or supplement(s) and symptom(s): _____
_____

38. Do you feel that you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

39. Do you feel much **worse** if you eat a lot of:
____ high fat foods ____ refined sugar (junk food)
____ high protein foods ____ fried foods
____ high carbohydrate foods (breads, pastas, potatoes) ____ 1 or 2 alcoholic drinks

40. Do you feel much **better** if you eat a lot of:
____ high fat foods ____ refined sugar (junk food)
____ high protein foods ____ fried foods
____ high carbohydrate foods (breads, pastas, potatoes) ____ 1 or 2 alcoholic drinks

41. Does skipping a meal greatly affect your symptoms? Yes____ No____

42. Have you ever had a food that you really craved or really "binged" on over a period of time? Yes____ No____
If yes, what food? _____

43. Have you ever had an aversion to certain foods? Yes____ No____
If yes, what food? _____

44. Please fill in the chart below about your bowel movements:

Frequency	✓	**Consistency**	✓	**Color**	✓
More than 3 per day		Soft and well formed		Medium brown consistently	
1-3 per day		Often float		Very dark or black	
4-6 per week		Difficult to pass		Greenish color	
2-3 per week		Diarrhea		Blood is visible	
1 or fewer per week		Thin, long and narrow		Varies a lot	
		Small and hard		Dark brown consistently	
		Loose but not watery		Yellow, light brown	
		Alternating between hard and loose/watery		Greasy, shiny appearance	

45. Intestinal gas: ____ Daily ____ Present with pain
____ Occasionally ____ Foul smelling
____ Excessive ____ Little Odor

46. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend / girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

FOR WOMEN ONLY:

47. Have you ever been pregnant? (If no, skip to question 53.) Yes____ No____

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? Yes____ No____

Have you had other problems with pregnancy? Yes____ No____

If so, please comment: _____

_____

48. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram_____
Pap Smear: ___ Normal ___Abnormal
Mammogram: ___ Normal ___ Abnormal

49. Have you ever used birth control pills? Yes____ No____ If yes, when _____

50. Are you taking the pill now? Yes____ No____

51. Did taking the pill agree with you? Yes____ No____ Not applicable _____

52. Do you currently use contraception? Yes____ No____
If yes, what type of contraception do you use? _____

53. Are you in menopause? No _____ Yes _____ If yes, age at last period_____
Do you take: Estrogen?___ Ogen?___ Estrace?___ Premarin?___ Other (specify)_____
Progesterone?___ Provera? ___ Other (specify) _____

54. How long have you been on hormone replacement therapy (if applicable)? _____

55. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?
Yes____ No____ Not applicable _____

56. Please check if these symptoms occur presently **or** have occurred in the past 6 months.

GENERAL:	**Mild**	**Mod-erate**	**Severe**
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	**Mild**	**Mod-erate**	**Severe**
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			

MOOD/NERVES, Cont'd:	Mild	Mod-erate	Severe
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
DIGESTION:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			

DIGESTION, Cont'd:	Mild	Mod-erate	Severe
Dry mouth			
Farting			
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
SKIN PROBLEMS:			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			

SKIN PROBLEMS, Cont'd:	Mild	Mod-erate	Severe
Eczema			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

SKIN, DRYNESS OF:	Mild	Mod-erate	Severe
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
LYMPH NODES:			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
NAILS:			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			
Toenails			
White spots/lines			

RESPIRATORY:	Mild	Mod-erate	Severe
Bad breath			
Bad odor in nose			
Cough - dry			
Cough - productive			
Hay fever : Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

URINARY:	Mild	Mod-erate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
FEMALE REPRODUCTIVE			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			

FEMALE REPRODUCTIVE, Cont'd:	**Mild**	**Mod-erate**	**Severe**
Premenstrual: Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			