

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If we sincerely believe your condition will not respond satisfactorily, we will not accept your case. If you have any questions, please ask. If you have anything you wish to bring to our attention, which is not asked on this form, please note it in the *Comments* section.

Thank you.

Please visit our website for more information about our clinic at <http://hsc.unm.edu/som/cfl/>

DEMOGRAPHIC INFORMATION:

Name _____

Height _____ Weight _____

Address _____

Employer _____

Occupation _____

e-mail address: _____

Marital Status:

Phone (1) _____

Single Married Separated

Phone (2/wk) _____

Divorced Widowed Partner

Primary Physician _____

Spouse/Partner's name: _____

Referring Physician _____

How did you hear about CFL?: _____

Date of Birth ____/____/____ Age _____

Emergency Contact Person _____ Contact Relationship _____

Phone Number to contact: _____ / _____

YOUR VISIT:

How did you hear/learn about our clinic? _____

What is the main issue/problem that you would like help with? _____

When did the problem begin (please be specific)? _____

To what extent does the problem interfere with your daily activities (work, exercise, sleep, sex, etc.)?

Have you been given a diagnosis for the problem? If yes, what? _____

What kind of treatments and/or therapies have you tried? _____

PAST MEDICAL HISTORY: (Please note dates)

Cancer _____ HIV/AIDS _____ Thyroid Disease _____
Diabetes _____ Rheumatic Fever _____ High Blood Pressure _____
Hepatitis _____ Heart Disease _____ Venereal Disease _____

Surgeries (type and date): _____

Significant Traumas (please date): _____

Significant Dental Work (please date): _____

Allergies (drugs, chemicals, foods, etc): _____

Occupational Stress (chemical, physical, psychological): _____

Birth History (prolonged labor, forceps delivery, premature, etc): _____

FAMILY MEDICAL HISTORY:

Cancer Heart Disease Asthma
 Diabetes Stroke Allergies
 High Blood Pressure Seizures Other _____

CURRENT MEDICATIONS:

What Medications and/or supplements are you taking? _____

Have you had many courses of antibiotic treatment recently? -Lots -Moderate -None

Have you had many courses of antibiotic treatment in the past? -Lots -Moderate -None

HABITS:

Do you have a regular exercise program? Yes No

If yes, please describe: _____

Are you or have you been on a restricted diet? Yes No

If yes, what kind and why? _____

(HABITS CONTINUED):

Please indicate use per day or per week (please put "0" if it doesn't apply to you):

Cigarettes _____ per _____	Tea _____ per _____
Alcohol _____ per _____	Soft Drinks _____ per _____
Drugs _____ per _____	Sugar _____ per _____
Coffee _____ per _____	Other _____ per _____

Please describe your average daily diet:

Morning _____

Afternoon _____

Evening _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING?:

Please check all symptoms that apply:

General

- Recurrent infections
- Night sweats
- Sweating easily
- Bleed or bruise easily
- Strong thirst (hot or cold)
- Thirst, no desire to drink
- Fatigue
- Sudden energy drops
Time of day _____
- Poor sleep
- Tremors
- Poor balance
- Edema
- Underweight
- Overweight

Skin

- Rashes
- Itching
- Eczema
- Oozing
- Pimples/acne
- Dry skin/scalp
- Recent Moles
- Change in hair/skin
- Other _____

**Head/Eyes/Ears/
Nose/Throat**

- Headaches
Where _____
When _____
- Migraines
- Dizziness
- Earache
- Discharge from ear
- Poor Hearing
- Ringing in ears
- Blurry vision
- Night blindness
- Color blindness
- Spots in front of eyes
- Eye pain
- Excessive tearing
- Squint
- Glasses
- Sore eyes
- Facial pain
- Nose bleeds
- Nasal discharge
- Blocked nose
- Snoring
- Grinding teeth
- Teeth problems

- Recurrent sore throat
- Hoarseness
- Tonsillitis
- Swollen glands
- Sores on lips/mouth
- Other _____

Cardiovascular

- Pacemaker
- High blood pressure
- Low blood pressure
- Chest discomfort/pain
- Heart palpitations
- Cold hands or feet
- Swelling of hands or feet
- Blood clots
- Spider veins
- Fainting
- Other _____

(CONTINUED ON PAGE 4)

Respiratory

- Difficulty breathing
- Pain with breathing
- Shallow breathing
- Shortness of breath
- Production of phlegm (color _____)
- Recurrent cough
- Coughing blood
- Bronchitis
- Pneumonia
- Asthma/Wheezing
- Status asthmaticus
- Other _____

Digestion

- Bad breath
- Change in appetite
- Nausea
- Vomiting
- Heartburn
- Indigestion
- Belching
- Abdominal pain or cramps
- Weight gain
- Weight loss
- Loose stools/diarrhea
- Strong smelling stools
- Bloody stools
- Pale stools
- Green stools
- Black stools
- Constipation
- Pain with passing stools
- Gas
- Rectal pain
- Hemorrhoids
- Anorexia nervosa
- Bulimia
- Other _____

Genito-urinary

- Pain upon urination
- Urgency with urination
- Frequent urination
- Blood in urine
- Decrease in urinary flow
- Unable to hold urine
- Incontinence at night
- Dribbling urination
- Kidney stones
- Prostate problems
- Impotency
- Change in sexual drive
- Rashes
- Do you wake to urinate? (How many times? ____)
- Other _____

Gynecological

- # of pregnancies _____
- # births _____
- # premature births _____
- # abortions _____
- Age of 1st menses _____
- # of days between menses cycle _____
- Duration of menses _____
- 1st day of last menses _____
- Age at menopause _____
- Date of last PAP _____
- PMS
- Irregular periods
- Painful periods
- Light periods
- Heavy periods
- Clots
- Fibroids
- Endometriosis
- Infertility
- Vaginal discharge
- Vaginal sores
- Postcoital bleeding
- Breast lumps
- Nipple discharge
- Other _____

Musculoskeletal

- Neck ache/pain
- Back ache/pain
- Knee ache/pain
- Shoulder pain
- Hand/wrist pain
- Foot/ankle pain
- Joint/Bone problem
- Torn tissues
- Prostheses
- Muscle pain/weakness
- Hernia
- Other _____

Neurological

- Seizures
- Nerve damage
- Paralysis
- Stroke
- Sleep disorder
- Concussion
- Vertigo
- Lack of coordination
- Loss of balance
- Poor memory
- Difficulty in concentrating
- Other _____

Behavioral

- Vacant
- Moody
- Easily susceptible to stress
- Aggressive/Bad temper
- Lose control of emotions
- Anxiety
- Panic attacks
- Depression
- Fear
- Substance abuse
- Other _____

Have you ever been treated for emotional problems? Yes No

Have you ever considered or attempted suicide? Yes No