[redacted] History Questionnaire

Name: [redacted] Date: 6-20-24

Date of Bi[redacted]

Please list the most important reason(s) you came in today:

1. want more flexibility + strength + balance + coordination
2.
3.
4.

What other health concerns do you have at this time?

1. Ataxia
2. heart
3. gut

Please list other doctors, chiropractors, acupuncturists and physical therapists you see and for what:

1. acupuncturist - General well being
2. Pers. Trainer + gyrotonics worker
3. speech therapist

List prescription medicine you now take (include dosage, reason you take it):

Medication	Dose per Day	How long?	Reason for medication
amlodipine	5 mg	6 yrs	High BP

List over-the-counter medicines, vitamins, and food supplements you take and why?:

Supplement	Dose per Day	How long?	Reason for medication
you have list			

Are there any adverse effects from any of the above? If so what is it and is it a concern?

Medical History (Please include dates):Any Major illnesses that have been diagnosed or suspected:

Illness	When?	How diagnosed? (lab, imaging, symptoms)

Injury/Trauma/Accidents
What? What was injured? When?
concussion 1960

Surgeries/Hospitalizations:
Surgery/Hospitalization When?
1. appendectomy 1978
2. knee replacement 2019
3. " 2024

Anaphylactic

Reactions or severe reactions (medications, food, stings) to:
gluten - dairy - bee sting 30 years ago

Sensitivities

(medication, supplements, foods, etc.)

What is your blood Type? A+ B+ AB+ O+ A- B- AB- O-

Recent Medical Care: Where did you last receive medical care? _____
For what reason(s)? _____

Date of last physical exam: _____ Date of last TB test: _____
Date of last lab work: _____ Date of last tetanus shot: _____

Do you visit the dentist annually or more frequently? Y N
Characterize your dental health
Poor __ (more than 5 fillings)____more than one root canal
Good _V_(3-4 fillings)____1 root canal
Great__ (0-2 fillings)____no root canals
Gum-periodontal health____Mild bleeding occasionally____Bleeding regularly
____ more extensive swelling/gum inflammation
Height 5'4" Weight 103 Max weight 120 when? 1970 Desired weight ____

Circle if the symptom has occurred in the **last year**. Please **check mark** if the symptom occurredin **the past**, **1** for not often, **2** for occasional, **3** for often.

General	Weight gain Weight loss Weight gain (20lbs) Weight loss (20 lbs) History of dieting	Chronic fatigue Afternoon fatigue Weakness Excessive thirst Anemia	Spontaneous sweating Night sweats Fever/chills	Heat intolerance 1/2 Cold intolerance Cold hands/feet 1 Other:
Skin	Dry skin Itchy skin Rashes Hives Bruise easily 3	Acne Eczema Psoriasis Shingles Fungal Rash/ringworm	Athlete's foot 3 Nail fungus Moles Varicose veins Bumpy skin back of arms	Any change to nails Any change to skin color Any change to moles Other:

Head	Headaches Migraines	Dizziness Vertigo	Trauma Hair Loss	Seizures Other:
Eyes **Last exam_**	Dry eyes Watery eyes Itchy eyes Eye pain Red eyes Eye discharge	Blurred vision Double vision Sensitive to light Poor night vision	Styes Cataracts Vision loss Other:	Vision correction: Nearsighted Farsighted Contacts Glasses Laser
Ears	Ear pain Itchy ears Waxy ears	Discharge from ears Ringing in ears Hearing loss	Ear infections Ear infections as child	Hearing Aids Other
Nose & Sinuses	Itchy nose Discharge from nosePhlegm	Hay-fever/Allergies Post nasal drip Nosebleeds Loss of smell	Breathes thru mouth Snores	CPAP use Other:
Mouth & Throat Last dental exam _____	Dry mouth Itchy mouth/lips Sores on mouth/lips Bad breath	Sore throat Difficulty swallowingLoss of taste Hoarseness	Dentures Inflamed/bleeding gums Teeth sensitivity Braces	Jaw clicking TMJ
Neck	Neck pain	Swollen glands	Trauma	Other:
Respiratory	Shortness of breath Wheezing Pain with breath Coughing up blood	Asthma Bronchitis/Pneumonia Persistent cough	Exposure to: Chemicals Solvents Particulates	Tuberculosis Other:
Cardiovascular Last EKG ___	High blood pressure Low blood Pressure High Cholesterol Chest pain Heaviness in legs Bleeding issues	Heart races Palpitations Chest tightness Difficulty breathing at night Swelling in ankles Stroke	Cold hands/feet Purple fingers/lips Heart murmur Dizzy on standing Exhaustion with mild exertion	Clots Varicose veins Spider veins Calf pain-night Calf pain-walking Other:
Gastrointestinal (upper) Last endoscopy -----	Poor appetite Excessive appetite/thirst Changes in appetite Trouble swallowing Stomach pain	Nausea Vomiting Burping Belching Heartburn H. pylori Ulcers	Intolerance to foods: (list food &rxn)) Gluten Dairy	Fatigue after eating Anal itching Liver disease Gall bladder disease Treated for parasites
Gastrointestinal (lower) Last colonoscopy 2007 Last rectal exam 2013	Abdominal pain Abdominal bloating Gas/flatulence History of abdominal/pelvic surgery	Constipation <1 stool a day Painful Stool Hemorrhoids Blood in stools Blood on stools	Stool hard to pass Foul smelling stool Loose stools Frequent stools >3 day Undigested food in stools	Stool shape: -one piece -little pellets -breaks up -other: Color: -yellow -green -brown -black
Kidney/Urinary	Frequent urination Urinate <3x day Can't hold urine	Kidney infections Bladder infections Urination at night	Dripping after urination Bed-Wetting	Color: Light yellow Dark yellow

	Urination with cough or sneeze	Pain/burning with urination	Other:	Red urine Cloudy Strong smelling
Musculoskeletal	Pain in- Arms Shoulders Neck Hands Upper back Lower back Hips Legs Knees Feet	Painful bones Tight Shoulders Pain Muscles Swollen knees/elbows Burning Spasms/cramps Morning stiffness	Chronic pain Loss of height ✓ Osteoporosis Unable to sit straight Activities Limited due to pain	Herniated/bulging disc Arthritis Rheumatoid arthritis Tendonitis # Broken bones ____ DEXA Y N When_____Normal?
Neurological	Fainting Dizziness/vertigo ✓ Numbness/tingling Where?_____ Trembling hands	Poor Concentration Memory loss -long-term -short term Lack of alertness	Loss of grip Loss of muscle tone ✓ Muscle weakness ✓ Head heavy Heavy extremities	Head trauma Other:
Endocrine	Hypothyroid -surgical -Hashimoto's -unknown cause Hyperthyroid Cold hands/feet Cold intolerance	Hypoglycemia Hyperglycemia -DM1 -DM2 -Medications Y N Excessive thirst	Fatigue Poor appetite Excessive Hunger	Unexplained weight gain / loss Other:
Immune	Slow wound healing Reactions to Vaccines Cancer Mononucleosis	Chronic fatigue syndrome Auto immune disorder _____	Chronically swollen glands Chronic Infections Chicken pox Shingles	Frequent colds/flus Herpes ✓ Warts Other:
Women only	Menses: Age of first: 13 Days bleed: 7 Length of cycle: 28 Date of last menses: Heaviest flow day: 3 Heavy days #pads/tampons: ✓ Clots? 0 Cramps 1 2 3 4 5 Medication Y N Occ Hysterectomy_____ Fibroids Cystic Pain	Sexually active Y N # Pregnancies 2 # Live births 2 Gender you are sexually active with? Men Women Both Type of birth control? -Birth control pills -IUD Cu+ / Hormone -Condoms -Implant -Depo shot - Vasectomy -Other	Spotting between menses PMS -irritability -moodiness -crave sweet -crave salt -bloating -breast tenderness -crave salt Fatigue with menses Miss menses Irregular menses	Vaginal -itching -discharge -odor -dryness Infections -yeast -bacterial -viral History of STI Y N _____ Difficulty conceiving Libido 1-5 _____
Women only	Breast Monthly self exam Y N Fibrous breast Breast fed a child Implants Reduction Nipple discharge	History of mammogram Abnormal mammogram + PAP history -Cryo -LEEP	Menopause Age 50 Yrs ago 50 Hot flashes Night sweats Moodiness Brain fog Vaginal dryness	Hormone replacement -standard -natural -herbal Other:
Men only PSA test Prostate exam	Sense of full bladder Difficulty urinating Pain with urination Wake >1x to urinate Dripping after urinationStrain with urination Discharge from penis Sore on	Discharge from penis Sore on penis History of STI Y N Premature ejaculation Erectile dysfunction Sexual difficulties Libido 1-5	Testicular pain Testicular lump Testicular monthly exam Y N History of prostatitis Pain in genitals	Sexually active Y N Gender you are sexually active with? Men Women Both Type of birth / STI control? Vasectomy

Has anyone in your family had and who?

Alcoholism	Arthritis	Asthma	Cancer: type

Glaucoma	Diabetes	Heart disease	Genetic disorder
		brother	aunt/a - Me, wife, mother

Mental illness	Gastrointestinal	Thyroid disease	Auto-immune
	~~IBS~~ sens if UC gf Me + Grother (colitis)		Sjbo - Me

Other _____

Rate your stress level (1=low 10=very high) 1 2 3 4 5 6 7 8 9 10

Circle and rate the contributors

Health ___ Work ___ Money ___ Kids ___ Marriage ___ Parents ___ Home ___

Other _____

In your everyday life, your present faith/spiritual practices are (1= Important, 10= very important)

1 2 3 4 5 6 7 8 9 10

Please rate your motivation to affect change in your health (1= unmotivated, 10= highly motivated)

1 2 3 4 5 6 7 8 9 10

Hobbies: everything

What do you do that brings you joy? grandchildren - family friends (hang out with)

Anything Else? beauty - nature

2966

Pa _____ Date 6-20-24

Th _____ tion so that we may provide you with more eff

Has anyone in your family had and who?

Alcoholism ______ Arthritis ______ Asthma ______ Cancer: type ______ ?

Glaucoma ______ Diabetes ______ Heart disease brother Genetic disorder ataxia - Me, mother, wife

Mental illness ______ Gastrointestinal IBS + sensitive gut me + brother (constant) Thyroid disease ______ Auto-immune Sibo - Me

Other______________________________

Rate your stress level (1=low 10=very high) (1) 2 3 4 5 6 7 8 9 10

Circle and rate the contributors

Health ___ Work ___ Money ___ Kids ___ Marriage___Parents ___ Home ___

Other ______________________________

In your everyday life, your present faith/spiritual practices are (1= Important, 10= very important)

1 2 3 4 5 6 7 8 9 (10)

Please rate your motivation to affect change in your health (1= unmotivated, 10= highly motivated)

1 2 3 4 5 6 7 (8) 9 10

Hobbies: everything

What do you do that brings you joy? (hang out with) grandchildren - family friends

Anything Else? beauty - nature

Patient signat... ...e 6-20-24

Thank you for ... to provide this information so that we may provide you with more effective care.

06

Addendum For Yoga Therapy

Prioritizing your physical body (skeletal, muscles, pain) name the most limiting to your life to the least limiting.

1. ataxia - speech, balance - energy - ~~stress~~ dizzy
2. weak legs
3. scar tissue from knee replacement
4. coordination walking

Do you have mobility restrictions? What are they? can't walk beyond 3 miles or

How would you describe your breathing? fine

When is your energy best and worst? best - good worst at night after daily activity

Season? Best spring Worst winter

Time of day? Best noon Worst night

What would you change about your sleep? earlier a bed

Overall How is your digestion 1 poor - 10 great 5

Food preferences (circle all apply) salty sour sweet pungent spicy bitter

Diet is _(Approx)__% (week) 10 meat 20 fish ___veg (raw) 10 veg (cooked)

20 grain 10 potatoes ____ fruit & eggs

____ processed _____ homemade _____ fast food _____ good restaurant

Meals per Day 4 When 10 1:30 700 4/5pm snacks

What interests do you have? art writing walking, photography & grandchildren

Do you actively engage in interests? Yes

Do you require motivation? no

3 Words that describe your personality 1 patient

2. empathic 3. positive/ optomistic

What is deeply meaningful to you? nature, friends, family

How much do you devote to this? a lot

How do you Cope with stress or difficult issues? staying in present, breathing and sensory stimulus - refrain from stress walking, meditating

Circle those above you consider positive all

What would you like to learn or teach others? work → stay positive