The Center for Medicine and Healing Arts

KARYN SHANKS MD

Heart. Hope. Healing

Confidential Health Questionnaire

General Information

Name_____ Age _____ Date _____

Date of Birth_____ Gender ___male ___female

Job Title_____

Nature of Business _____

Primary Address _____

_____

Home Phone _____

Cell Phone _____

Work Phone _____

Fax _____

E-mail address _____

I would like to receive free weekly health-related articles by Dr. Shanks via email: _____Yes _____No

Emergency Contact _____

Relationship _____

Primary Care Physician: *Name* _____*Phone*_____

*Address*_____*Fax*_____

Referred By _____

Pharmacy Information

Primary Pharmacy: Name _____ Phone_____

Address_____ Fax*_____

Compounding Pharmacy: Name_____ Phone_____

Address_____ Fax*_____

*It is important that you provide your pharmacy's fax number

Credit Card Information

This information will be kept in a secure location at all times. It will be used to secure your new client appointment and to cover the cost of phone consultations, supplement orders, missed appointments and other services. We accept VISA, MasterCard and Discover.

Primary Card

Name on Card_____ Card Type _____

Account Number_____ Expiration Date_____ CVV _____

Billing Zip Code_____

Secondary Card

Name on Card_____ Card Type _____

Account Number _____Expiration Date _____ CVV_____

Billing Zip Code_____

Allergies

Medication/Supplement/Food	Reaction

Primary Concerns

What is the purpose for today's visit?

What are your goals?

What are the three top problems you would like to solve?

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

Please list current and ongoing problems in order of priority to you:

Describe problem (ex: fatigue)	mild	mod	severe	Prior treatment & results (excellent, good, fair, etc)

Medical History

Diseases/Diagnoses/Conditions: Please circle all that apply, now or in the past, and provide dates.

Gastrointestinal	**Genital and Urinary Systems**
Irritable Bowel Syndrome	Kidney Stones
Inflammatory Bowel Disease	Gout
Crohn's Disease	Interstitial Cystitis
Ulcerative Colitis	Urinary Tract Infections
Gastritis or Gastric Ulcers	Yeast Infections
GERD (reflux)	Erectile/Sexual Dysfunction
Celiac Disease	Vaginal Dryness
Small Bowel Bacterial Overgrowth	Urinary Incontinence
Other	Other
Cardiovascular	**Musculoskeletal**

Heart Attack	Osteoarthritis
Other Heart Disease	Fibromyalgia
Stroke	Chronic Pain
Irregular Heart Rhythm	Major Injuries
High Blood Pressure	Other
Rheumatic Fever	
Mitral Valve Prolapse	**Inflammatory/Autoimmune**
	Chronic Fatigue Syndrome
Metabolic/Endocrine	Autoimmune Disorder
Type 1 Diabetes	Rheumatoid Arthritis
Type 2 Diabetes	Lupus SLE
High blood sugar	Immune Deficiency Disorder
Low blood sugar	Herpes—Genital or Oral
Hypothyroidism	Severe Infectious Disease
Hyperthyroidism	Frequent Infections
Adrenal Problems	Food Allergies/Sensitivities
Endocrine Problems	Environmental Allergies
Polycystic Ovarian Syndrome	Chemical Sensitivities
Infertility	Latex Allergy
Weight Gain	Other
Weight Loss	
Frequent Weight Fluctuations	**Respiratory Diseases**
Bulimia	Asthma
Anorexia	Chronic Sinusitis
Binge Eating Disorder	Bronchitis
Other Eating Disorder	Emphysema
Other	Pneumonia
	Tuberculosis
Cancer	Sleep Apnea
Lung Cancer	Chronic Cough
Breast Cancer	Other
Colon Cancer	
Skin Cancer	**Skin Diseases**

Prostate Cancer	Eczema
Ovarian Cancer	Psoriasis
Other	Acne
	Melanoma
Neurological/Mood/Behavior	Skin Cancer
Depression	Other
Anxiety	
Bipolar Disorder	**Surgeries**
Schizophrenia	Appendectomy
Migraine Headaches	Hysterectomy +/- Ovaries
Other Headaches	Gall Bladder
ADD/ADHD	Hernia
Autism	Tonsillectomy
Cognitive Impairment	Dental Surgery
Parkinson's Disease	Knee/Hip Replacement
Multiple Sclerosis	Heart: Bypass or Valve
ALS	Angioplasty or Stent
Seizure Disorder	Pacemaker
Memory Problems	Other
Vertigo	
	Women's Health
Injuries	Hysterectomy
Back	Menopausal Symptoms
Neck	PMS
Head	Vaginal Dryness
Bone Fractures	Low Libido
Other	Uterine Fibroids
	Heavy Menstrual Blood Flow
Blood Type	Severe Menstrual Cramping
A, B, AB, O, Rh+/-, Unknown	Pelvic Pain
	Hormone Replacement Therapy

Hospitalizations

Date	Reason

Additional Comments about Medical History:

Women's Health History

Please fill in or circle all that apply and provide dates.

Obstetrical History	**Hormonal Disorders**	**Menstrual History**
Pregnancies #	Fibrocystic Breasts	Age of 1st period
Miscarriages #	Endometriosis	Menses frequency
Post Partum Depression	Uterine Fibroids	Length
Caesarean	Infertility	Pain
Vaginal Deliveries	Painful Periods	Clotting
Abortion	Heavy Periods	Irregularity?
Living Children #	PMS	Date of Last Period
Toxemia	Hot Flashes	Contraception?
Gestational Diabetes	Mood Swings	Type
Baby Over 8 Pounds	Vaginal Dryness	
Other	Low Libido	**Hormone Therapy**
	Heavy Bleeding	What?

Testing	Joint Pain	For How Long?
Last Mammogram	Memory Problems	
Last PAP	Weight Gain	
Abnormal PAP?	Urinary Incontinence	
Bone Density?	Palpitations	
Results		
Previous Breast Biopsy?		
Diagnosis		

Additional Comments About Women's Health History:

Men's Health History

Please fill in and circle all that apply.

Prior PSA?	Urinary Urgency
PSA Level	Urinary Hesitancy or Change in Stream
	Loss of Control of Urine
Prostate Enlargement	
Prostate Infection	Prior Low Testosterone?
Change in Libido	Testosterone Levels
Impotence	Hormone Therapy
Trouble Getting Erection	What?
Trouble Maintaining Erection	For How Long?
Urination at Night	

Additional Comments About Men's Health History:

Gastrointestinal History

Foreign Travel? Where?_____

Wilderness Camping? Where?_____

Have you ever had severe gastroenteritis or diarrhea? Explain _____

_____

How is your digestion? _____

Do you feel bloated after meals? _____

Are you ever constipated? _____

Do you have any food sensitivities? Explain _____

_____

Antibiotic History

If you have ever taken antibiotics (even for common childhood disorders like ear infections) please list condition(s) and length of prescription(s): _____

_____

_____

Client Birth History

Full term or premature? _____

Pregnancy Complications? _____

Birth Complications? _____

Breast Fed? How long? _____ Bottle fed?_____

Age of Introduction of Solid Foods_____ Dairy_____ Wheat_____

Dental History

How many silver mercury fillings do you have? _____

How many times daily do you brush your teeth?_____ Floss?_____

Circle all that apply: Gold Fillings Root Canals Implants Tooth Pain Bleeding Gums Gingivitis Problems with Chewing Jaw Pain

Medications and Supplements

Current Medications

Medication	Dose	Frequency	Start Date (mo/yr)	Reason for Use

Previous Medications

Medication	Dose	Frequency	Start Date (mo/yr)	Reason for Use

Nutritional Supplements (Vitamins, Minerals, Herbs, Homeopathy)

Supplement/Brand	Dose	Frequency	Start Date (mo/yr)	Reason for Use

Have your medications or supplements ever caused problems or side effects?

Have you had prolonged or regular use of NSAIDS (ibuprofen, Aleve, Advil, etc) or aspirin?

Have you had prolonged or regular use of Tylenol or Acetaminophen?

Have you had prolonged or regular use of acid blocking drugs (Ranitidine, Prilosec, Nexium, etc)?

Frequent or long term antibiotics?

Use of steroids (prednisone, nasal steroids) in the past?

Use of oral contraceptives or hormone therapy?

Family Health History

Have you had blood relatives with: (circle all that apply, list family member(s) and age of onset, if known)

Autoimmune Disorders _____

Celiac Disease _____

Thyroid or Other Endocrine Disorder _____

Neurodegenerative Disorder (MS, ALS, PD, Alzheimer's) _____

Depression _____

Mental Illness _____

Colon Cancer _____

Ovarian Cancer _____

Breast Cancer _____

Prostate Cancer _____

Osteoporosis _____

Heart Disease _____

Diabetes _____

Addiction (alcohol, drugs, food, etc) _____

Other Serious Illnesses (please give details) _____

_____

Please fill in all known information:

Family Member	Age	Major Health Issues	Age at Death	Cause of Death
Mother				
Father				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Children:				
Male/Female				
Male/Female				
Male/Female				
Male/Female				
Male/Female				
MGM				
MGF				
PGM				
PGF				

Note: If you were adopted, please fill in what you know about your biological or blood relatives.

Do you have any special concerns about your family health history?

Social History

Nutrition History

Have you ever had a nutrition consultation?

Have you made any changes in your eating habits because of your health?

If so, describe: _____

Do you currently follow a special diet or food plan?

Explain: _____

Height (ft/in)	Current Weight
Usual Weight Range	Desired Weight Range
Highest Adult Weight	Lowest Adult Weight
Weight Fluctuations	Body Fat %

How often do you weigh yourself?

What foods do you avoid?

What are your absolute favorite foods?

Do you grocery shop? If not, who does your shopping?

Do you read food labels?

Do you cook? If not, who does your cooking?

How many meals do you eat out per week?

The important thing I should change about my diet to improve my health is: _____

_____

Psychosocial History

Do you feel significantly less vital than you did a year ago?
Are you happy?
Have you ever experienced major losses in your life?
Do you spend the majority of your time and money to fulfill responsibilities and obligations?
Would you describe your experience as a child in your family as happy and secure?

What type of work do you do? Where?

How many hours per week do you typically spend at work?

Do you enjoy your job? Explain.

Who do you live with currently?

Are you married/divorced/partnered/single/single parent/blended family? Explain.

What are your current major stressors (personal, work, relationships, health, etc.)?

Do you believe stress is presently reducing the quality of your life?

Do you have any significant relationship concerns? Explain.

Do you feel your life has meaning and purpose?

Are there areas of your life in which you do not feel free to fully express your feelings and emotions? Explain.

What are your hobbies?

Are you actively engaged in any of them currently? Explain.

What do you do for fun? How often?

What are your community activities?

What are your religious or spiritual activities (church, prayer, meditation, etc.)?

Do you practice meditation or other relaxation techniques? How often?

What do you do (yoga, meditation, imagery, positive affirmations, breathing, tai chi, prayer, other)?

Have you ever been abused, a victim of a crime, or experienced significant trauma?

Personal Habits

Smoking

Do you currently smoke? How many years? Packs per day?

Attempts to quit?

Are you a former smoker? For how long? When did you quit?

Alcohol

How many drinks currently per week? Circle below: *1 drink=5 ounces wine, 12 ounces beer, 1.5 ounces spirits*

None 1-3 4-6 7-10 >10

Previous alcohol intake? Mild Moderate High None

Have you ever been told you should cut down your alcohol intake?

Do you get annoyed when people ask about your drinking?

Do you ever feel guilty about your alcohol consumption?

Do you ever take an eye-opener?

Do you notice a tolerance to alcohol (can you "hold" more than others)?

Have you ever been unable to remember what you did during a drinking episode?

Do you get into arguments or physical fights when you have been drinking?

Have you ever been arrested or hospitalized because of drinking?

Have you ever thought about getting help to control or stop your drinking?

Other Substances

Caffeine Intake? Coffee cups/day: Tea cups/day:

Caffeinated Sodas or Diet Soda Intake?

How many per day? List favorite types:

Are you currently using any recreational drugs? What type?

Exercise

Activity	Type	Frequency per week	Duration in Minutes
Stretching/Rolling Out			
Cardio/Aerobics			
Strength Training			
Cross-Training/Crossfit			
Yoga, Pilates			
Sports			

Other			

Rate your level of motivation to exercise: Low Medium High

List problems that limit activity:

_____

_____

Do you feel unusually fatigued after exercise?

If so, describe: _____

_____

Do you sweat when exercising?

Sleep

Average number of hours you sleep each night:

Do you have trouble falling to sleep?

Do you have trouble staying asleep? How many times do you wake up each night?

Do you feel rested upon awakening?

Do you wake up to an alarm?

Do you have problems with insomnia?

Do you snore?

Do you use any sleep aids? Explain:_____

Roles/Relationships

Marital Status: single married divorced gay/lesbian long-term partner widowed

List Children: Full Names	Age	Gender

Who is living in household? Number_____ Names _____

Their employment/occupations:

Resources for emotional support?

How well have things been going for you?	Very Well	Fine	Poorly	N/A
Overall				
At School				
In Your Job				
In Your Social Life				
With Close Friends				
With Sex				
With Your Well Being				
With Your Significant Other				
With Your Children				
With Your Parents				
With Your Spouse				

Environmental and Detoxification Assessment

Do you have adverse food reactions or sensitivities? If so, list all _____

_____

Do you have any food allergies? If so, list all _____

Do you have an adverse reaction to caffeine?

When you drink caffeine do you feel: Irritated or Wired? Aches or Pains?

Do you react adversely to any of the following: Monosodium glutamate (MSG) Aspartame (Nutrasweet)

Bananas Garlic Onion Cheese Citrus Foods Chocolate Alcohol Red Wine

Sulfite containing foods Preservatives

Other:_____

Which of the following significantly effect you? Cigarette smoke Perfumes/Colognes

Auto Exhaust Fumes Other:_____

Exposures in your home or work: Chemicals Mold Electromagnetic Radiation

Have you ever had jaundice?

Have you ever had liver disease or Gilbert's Syndrome? Explain _____

Have you had significant exposure to any harmful chemicals such as: Herbicides Insecticides

Pesticides Organic Solvents Heavy Metals Other: _____

Chemical Name, Date, Length of Exposure:_____

Do you dry clean your clothes regularly?

Do you now or have you ever lived or worked in a damp or moldy environment or had other mold exposure?

Do you have pets or farm animals?

Symptom Review

Please circle all symptoms you have experienced in the past 6 months.

General	Headaches or Migraine	Arms/legs
Cold hands and feet	Sensitivity to loud noises	Ear canals
Cold intolerance	Vision problems	Eyes
Low body temperature	Macular degeneration	Feet/hands
Low blood pressure	Vitreous detachment (floaters)	Scalp
Daytime sleepiness	Retinal detachment	Nose
Difficulty falling to sleep	**Skin Problems**	Roof of mouth/throat
Early waking	Acne	Dry skin
Fatigue	Athlete's foot	Generalized itching
Fever	Bumps on back of upper arms	Generalized dryness
Flushing	Dark circles under eyes	**Musculoskeletal**
Heat Intolerance	Ears get red	Back muscle spasms
Night Walking	Easy bruising	Calf cramps
Nightmares	Lack of sweating	Chest tightness
No dream recall	Eczema	Foot cramps
Weight loss or gain	Hives	Joint deformity
Brain fog	Jock Itch	Joint pain
Head, Eyes and Ears	Lackluster skin	Joint stiffness
Conjunctivitis	Moles with color/size change	Joint swelling/redness
Distorted sense of smell	Rash	Muscle pain
Distorted taste	Red skin	Muscle stiffness
Ear fullness	Sensitivity to insect bites	Muscle weakness
Ear pain	Sensitivity to poison ivy/oak	Muscle twitching
Ear ringing or buzzing	Shingles	Neck muscle spasms
Lid margin redness	Strong body odor	Tendonitis

Eye crusting	Hair loss	Tension headache
Eye pain	Excessive hair growth	TMJ problems
Hearing loss	Vitiligo	
Hearing problems	**Itching Skin**	
Headache	Anus	
Mood/Neurological	Salt cravings	Intolerance to:
Agoraphobia	Carbohydrate cravings	Lactose
Anxiety	Sweet cravings	All dairy products
Auditory hallucinations	Chocolate cravings	Wheat
Black-outs	Caffeine dependency	Gluten
Depression	**Digestion**	Corn
Difficulty concentrating	Anal spasms	Eggs
Balance problems	Bad teeth	Fatty foods
Difficulty with thinking	Bleeding gums	Yeast
Difficulty with judgment	Bloating	Liver disease
Speech problems	Bloating after meals	Abnormal liver tests
Memory problems	Blood in stools	Lower abdominal pain
Dizziness (spinning)	Burping	Mucus in stools
Fainting	Canker sores	Periodontal disease
Fearfulness	Cold sores	Sore tongue
Irritability	Constipation	Strong stool odor
Light-headedness	Lip cracking	Undigested food in stools
Numbness or tingling	Cramps	Fructose intolerance
Phobias	Dentures	FODMAP intolerance
Panic attacks	Diarrhea	SIBO
Paranoia	Alternating diarrhea/constipation	**Lymph Nodes**
Seizures	Difficulty swallowing	Enlarged (location)
Suicidal thoughts	Dry mouth	Tender (location)
Tremor/trembling	Excess gas	**Urinary**
Visual hallucinations	Fissures	Bed wetting
Eating	Reflux	Hesitancy
Binge eating	Heartburn	Infection
Bulimia	Hemorrhoids	Kidney disease

Can't gain weight	Maldigestion	Leaking/incontinence
Can't lose weight	Nausea	Pain/burning
Frequent dieting	Upper abdominal pain	Urgency
Poor appetite	Vomiting	Prostate enlargement
Nails	Irregular pulse	Heavy periods
Bitten	Palpitations	Irregular periods
Brittle	Phlebitis	No periods
Curve up	Swollen ankles/feet	Scanty periods
Frayed	Varicose veins	Spotting between periods
Fungus	**Male Reproductive**	Vaginal dryness
Pitting	Penile discharge	Hot flashes
Ragged cuticles	Ejaculation problems	Night sweats
Ridges	Genital pain	Mood changes
Soft	Impotence	
Thickening	Prostate or urinary infection	
White spots or lines	Lumps in testicles	
Respiratory	Poor libido (sex drive)	
Bad breath	**Female Reproductive**	
Bad odor in nose	Breast cysts	
Cough-dry	Breast lumps	
Cough-productive	Breast tenderness	
Hoarseness	Ovarian cysts	
Sore throat	Poor libido (sex drive)	
Hay fever	Vaginal discharge	
Nose bleeds	Vaginal odor	
Post nasal drip	Vaginal itch	
Sinus fullness	Vaginal pain with sex	
Sinus infection	Premenstrual:	
Shortness of breath	bloating	
Snoring	breast tenderness	
Wheezing	insomnia	
Winter stuffiness	fatigue	
Cardiovascular	irritability	

Angina/chest pain	other	
Breathlessness	Menstrual:	
Heart murmur	cramps	

Routine Health Screenings

Test/Procedure (most recent) **Date Received** **Result**

Routine physical exam_____

Pap smear/pelvic exam_____

Bone Density Testing_____

Prostate exam_____

Mammogram_____

Colonoscopy_____

Flexible Sigmoidoscopy_____

Barium Enema_____

Fecal Occult Blood testing_____

Thyroid blood test_____

PSA_____

Cholesterol/lipids_____

Diabetes screening (blood sugar/hemoglobin A1C)_____

HIV testing_____

Routine eye exam_____

Routine dental exam_____

Please explain in detail how abnormal results (if any) were followed up upon or treated:

Immunizations	**Date(s) received**	**Immunizations**	**Date(s) received**
Hepatitis B		Childhood vaccines	
Tetanus		T.B.	

Pneumonia Other:

Influenza

*Have you experienced any unusual reactions to vaccines received? Explain.

Potential Health Risks: please circle all that apply to you and provide explanation (including dates)

Dental mercury amalgams (silver fillings)

Root canal surgery

Radiation exposure

Asbestos exposure

Grain dust exposure

Significant exposure to fumes/chemicals/dusts/molds

Blood transfusion

If yes, have you received blood testing for hepatitis? Results:

Unprotected sex

Intravenous drug use

Do you use your cell phone while driving?

Do you wear your seatbelt consistently?

Are there any firearms in your home? Where are they kept?

Please rate your current level of:

	Least										Most
Pain	0	1	2	3	4	5	6	7	8	9	10
Location:											
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Health	0	1	2	3	4	5	6	7	8	9	10
Nutrition	0	1	2	3	4	5	6	7	8	9	10
Stress (work)	0	1	2	3	4	5	6	7	8	9	10
Stress (personal)	0	1	2	3	4	5	6	7	8	9	10
General happiness	0	1	2	3	4	5	6	7	8	9	10
Meaning and purpose in life	0	1	2	3	4	5	6	7	8	9	10

What are your strengths/ resources?

What are your weaknesses/limitations?

Your Health and Major Life Event Timeline

Please record all major health events (include childhood infections/treatments, hospitalizations or significant illnesses and symptoms) as well as all major life events (include births, deaths, relationships, traumas, major stresses and anything that you can recall that seems significant to you). If the space below feels too confining, please feel free to record your chronological history on separate sheets.

Year/Age	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Birth												
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Readiness Assessment

Scale of 5 (very willing) to 1 (not willing): circle

In order to improve my health, I am willing to:

Significantly modify my diet	5	4	3	2	1
Take several nutritional supplements each day	5	4	3	2	1
Keep a food and symptom diary	5	4	3	2	1
Modify my lifestyle (sleep habits, work demands)	5	4	3	2	1
Practice relaxation techniques	5	4	3	2	1
Engage in regular exercise	5	4	3	2	1
Have periodic lab tests to gauge progress	5	4	3	2	1
Make myself a high priority in my life	5	4	3	2	1
Make self-care a high priority in my life	5	4	3	2	1

What obstacles to you see as standing in the way of self-care as listed above:

How supportive will others in your household be as you work on implementing the above changes?

What do you need to support you on your journey to health and wellness?

Three Day Diet Diary

What we eat is enormously important to our health and vitality. Exploring your current eating habits will provide invaluable clues about symptoms and problems you may be experiencing and will show us what changes need to be made to improve or optimize your health. Please complete this three-day diet diary on 3 consecutive, “typical” days, including at least one weekend day if possible.

-Record the information as soon as possible after eating.
-Do not change your normal eating behavior for the purpose of this diary.
-Describe the food or beverage consumed: e.g. toast—what kind of bread; chicken—fried, baked, etc.
-Record the amount of food eaten: 8 ounces, ½ cup, 1 teaspoon, etc.
-Include any added items: e.g. tea with 1 tsp of sugar, potato with 2 tsp of butter, etc.
-Include any spices or seasonings you use.
-Record all beverages, including water.
-List all bowel movements and their consistency (formed, loose, firm, hard, liquid, etc).

Date/Time	Food	Amount	Time	Beverage	Amount
Date/Time	Food	Amount	Time	Beverage	Amount

Bowel Movements

Date/Time	Consistency/Associated Symptoms

Additional information or comments:

Thank you so much for the time and effort you have put into completing this questionnaire! This is vitally important for us both as we seek to understand your health story and find solutions to current problems and concerns. If there is more that you would like me to know about you, please feel free to attach additional pages.

I look forward to your visit!

Karyn Shanks, MD
The Center for Medicine and Healing Arts

KARYN SHANKS MD
Heart, Hope, Healing