Patient Questionnaire

Date *

Month Day Year

Full Name *

First Name Middle Name Last Name

Prefferred Name

Genetic Background *

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

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code Country

Primary Phone

Area Code Phone Number

E-mail *

example@example.com

Best way to contact? *

Primary Physician *

Name

Phone

City

Other Pertinent Provider

Name

Phone

Referred By *

Complaints / Concerns

What do you hope to achieve in your visit(s)? *

Reflection

Name your three main health/nutrition concerns you would like to remove from your life if you could. *

Please describe any pain complaints you would like to address in order of priority. *

Can you recall 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? *

Additional Comments:

Nutrition

Check all the factors that apply to your current lifestyle and eating habits:

Type a question *

- ☐ Fast eater
- ☐ Love to cook
- ☐ Love to eat
- ☐ Erratic eating patterns
- ☐ Eat too much/overeat
- ☐ Late night eating
- ☐ Confused about food/nutrition
- ☐ Family members have different tastes
- ☐ Rely on convenience items
- ☐ Do not plan meals
- ☐ Vegan
- ☐ Macrobiotic
- ☐ Organic
- ☐ Raw Foods
- ☐ Gluten-Free
- ☐ Struggle with eating
- ☐ Negative relationship with food
- ☐ "Eat because I have to" issues
- ☐ Emotional eater
- ☐ Eat fast food frequently
- ☐ Live or often eats alone
- ☐ Time constraints
- ☐ Dislike "healthy food"
- ☐ Poor snack choices
- ☐ Travel frequently
- ☐ Vegetarian
- ☐ High Protein
- ☐ Local
- ☐ Standard American Diet (USDA)
- ☐ Gluten/Casein Free

Please note any additional comments about your nutrition/eating habits: *

Physical Activity

Do you engage in moderate cardiovascular physical activity for a minumum duration of 20 minutes at least 3 days a week? *

Please indicate the type of exercise you are currently engaging in. *

	Type/Intensity (low/mod/high)	# Day Per Week	Duration (mins)
Stretching/Yoga			
Cardio/Aerobics			
Strength Training			
Sports or Leisure			
Other			

Note any problems that limit your physical activity: *

Daily Stressors

Rate on a scale of 1 (low) to 10 (high)

Work *

	1	2	3	4	5	6	7	8	9	10	
Low	○	○	○	○	○	○	○	○	○	○	High

Family *

	1	2	3	4	5	6	7	8	9	10	
Low	○	○	○	○	○	○	○	○	○	○	High

Relationships *

	1	2	3	4	5	6	7	8	9	10	
Low	○	○	○	○	○	○	○	○	○	○	High

Finances *

	1	2	3	4	5	6	7	8	9	10	
Low	○	○	○	○	○	○	○	○	○	○	High

Health *

	1	2	3	4	5	6	7	8	9	10	
Low	○	○	○	○	○	○	○	○	○	○	High

Education *

	1	2	3	4	5	6	7	8	9	10	
Low	○	○	○	○	○	○	○	○	○	○	High

Physical Activity *

	1	2	3	4	5	6	7	8	9	10	
Low	○	○	○	○	○	○	○	○	○	○	High

Career Choice *

	1	2	3	4	5	6	7	8	9	10	
Low	○	○	○	○	○	○	○	○	○	○	High

Other

Lifestyle Information

Is there any unusual excess stress in your life? *

Please explain: *

Do you easily handle stress? *

How do you handle stress? Please explain: *

What nourishes you? *

Do you feel comfortable discussing any past physical/emotional/sexual abuse history during our encounter?

- Yes
- No

Do you wake up during the night? *

If yes, how many times?

How many hours of sleep do you get per night? *

If you take any supplements to help with sleep, please list them:

In order to improve your health, how willing are you to:(Rate on scale of 5-very willing to 1-not willing)

	5	4	3	2	1
Significantly modify your diet	○	○	○	○	○
Take nutritional supplements each day	○	○	○	○	○
Keep a record of everything you eat each day	○	○	○	○	○
Modify your lifestyle (work demands, sleep habits, exercise)	○	○	○	○	○
Practice a relaxation technique	○	○	○	○	○
Engage in regular exercise/physical activity	○	○	○	○	○
Have periodic lab tests to assess your progress	○	○	○	○	○

What do you think would make the most difference in your overall health? *

Patient Narrative

Please SHARE your health and medical story that would help us help you. SHARE your challenges and goals you would like to accomplish on this journey to wellness.

*

Please list all medical conditions for which you are treated:

Please list all past surgeries:

Please list any hospitalizations including the reason and date:

Please list all pertinent family history:

Please list all medications and supplements you currently take including dosage and frequency:

Please list any food/drug allergies. If no known allergies, write "none"

Do you use or have you used in the past tobacco, alcohol, or illicit drugs?

- ☐ Yes
- ☐ No

If yes, please list the substance, amount, and last time used:

Acknowledgement

I am solely responsible for the decision to see Dr. Danielle Forster, DO for Integrative and Regenerative medicine. I recognize that some recommendations may not prove to be successful. I understand some recommendations may be novel. I agree to participate in an active manner, monitor my progress, and report any concerns to Dr. Forster. I also understand that any significant symptoms should be reported to Dr. Forster immediately. I understand that Dr. Forster does not practice primary care medicine. I agree to maintain a relationship with my own primary care physician for general medical needs. I understand that Dr. Forster does not practice chronic pain management with opioid analgesics.

By entering your name, you certify that the information you have provided is accurate and that you acknowledege the above paragraph.

Patient Name *

Submit