The Initial Medical Questionnaire

Patient Name:_____Age_____Today's Date/Time:_____

What is the reason for your visit this time?_____
_____

Any current stressors: _____

Allergies to medications/food:_____

Medical Problems: Please mark all that apply to you.

•No General Medical Condition	•Anemia	•Arterial Sclerotic Disease
•Arthritis	•Asthma	•Blind/Visually impaired
•Cancer	•Carpal Tunnel Syndrome	•Chronic pain
•Cirrhosis	•Deaf/Hearing Impaired	•Diabetes
•Digestive Disorders	•Epilepsy/Seizure	•Heart Disease
•Hepatitis	•Hypercholesterolemia	•Hypertension
•Hypothyroidism	•Migraines	•Multiple Sclerosis
•Obesity	•Osteoporosis	•Parkinson's Disease
•Skin problems	•Stroke	•Sexual Transmitted Disease(STD)
•Others		

Current Medications (list all the medications you are taking for medical/mental illness)

List the over the counter medications and other supplements:

_____

When was your last physical examination? _____

Past Surgeries: Yes/No _____

Experienced Trauma: Yes/No_____

Any current illicit drugs use: Yes/No _____

If you are female, do you have a regular period? Yes/No
If you are female, do you think you are pregnant currently? Yes/No