

# IMPORTANT HEALTH QUESTIONNAIRE

Your doctor would like you to fill in the following health questionnaire. These answers may be very important in helping you achieve good health. Please fill in the entire questionnaire and return to one of the doctor's staff as soon as you are done.

Your Name \_\_\_\_\_ Date \_\_\_\_\_

Best phone number and time to reach you with an evaluation of your questionnaire...

Area Code \_\_\_\_\_ Phone Number \_\_\_\_\_ Best time to call \_\_\_\_\_

If you are filling in this questionnaire for you child, please write his or her name and age here...

Name \_\_\_\_\_ Age \_\_\_\_\_ Has this child seen this doctor before? YES NO

Please indicate any symptoms you have suffered...

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Irritability                               | <input type="checkbox"/> Rocking movements                             | <input type="checkbox"/> General food sensitivities          |
| <input type="checkbox"/> Anxiety / Nervousness                      | <input type="checkbox"/> Frequent leg cramps                           | <input type="checkbox"/> Bloating feeling most of the time   |
| <input type="checkbox"/> Difficulty breathing when anxious          | <input type="checkbox"/> Diminished touch sensation                    | <input type="checkbox"/> Abnormal cramps                     |
| <input type="checkbox"/> Restlessness                               | <input type="checkbox"/> Numbness and tingling of hands,               | <input type="checkbox"/> Stomach problems                    |
| <input type="checkbox"/> Exaggerated response to stimulation        | feet, fingers, toes, or lips   | <input type="checkbox"/> Frequent or recurring heartburn     |
| <input type="checkbox"/> Fearfulness                                | <input type="checkbox"/> Tremors / trembling of hands,                 | <input type="checkbox"/> Frequent urination during the night |
| <input type="checkbox"/> Emotional instability                      | feet, lips, eyelids, or tongue   | <input type="checkbox"/> Chronic diarrhea or constipation    |
| <input type="checkbox"/> Lack of self-control                       | <input type="checkbox"/> Burning sensation of lips, face               | <input type="checkbox"/> Low blood pressure                  |
| <input type="checkbox"/> Fits of anger w/violent irrational conduct | <input type="checkbox"/> Burning in throat                             | <input type="checkbox"/> High blood pressure                 |
| <input type="checkbox"/> Loss of self-confidence                    | <input type="checkbox"/> Inflammation of lining of the mouth           | <input type="checkbox"/> Increased heart rate                |
| <input type="checkbox"/> Constant death wish                        | <input type="checkbox"/> Ulcers in mouth or on tongue                  | <input type="checkbox"/> Menstrual pains                     |
| <input type="checkbox"/> Shyness or timidity                        | <input type="checkbox"/> Twitching or jerking of muscles               | <input type="checkbox"/> Disturbances in menstrual cycle     |
| <input type="checkbox"/> Being easily embarrassed                   | <input type="checkbox"/> Difficulty walking                            | <input type="checkbox"/> Loosening of teeth                  |
| <input type="checkbox"/> Loss of memory                             | <input type="checkbox"/> Difficulty talking                            | <input type="checkbox"/> Excessive salivation                |
| <input type="checkbox"/> Inability to concentrate                   | <input type="checkbox"/> Difficulty swallowing                         | <input type="checkbox"/> Foul Breath                         |
| <input type="checkbox"/> Difficulty making decisions                | <input type="checkbox"/> Loss of balance                               | <input type="checkbox"/> Metallic taste                      |
| <input type="checkbox"/> Lethargy / drowsiness                      | <input type="checkbox"/> Food sensitivity to eggs or milk              | <input type="checkbox"/> Vomiting                            |
| <input type="checkbox"/> Withdrawal                                 | <input type="checkbox"/> Low body temperature                          | <input type="checkbox"/> Loss of appetite                    |
| <input type="checkbox"/> Hallucinations                             | <input type="checkbox"/> Cold, clammy skin, especially hands & feet    | <input type="checkbox"/> Anorexia                            |
| <input type="checkbox"/> Mood swings                                | <input type="checkbox"/> Excessive perspiration, frequent night sweats | <input type="checkbox"/> Loss of weight                      |
| <input type="checkbox"/> Mental depression / despondency            | <input type="checkbox"/> Constant or frequent pain in joints           | <input type="checkbox"/> Low blood pressure                  |
| <input type="checkbox"/> Ringing in the ears                        | <input type="checkbox"/> Unexplained numbness or burning sensations    | <input type="checkbox"/> Speech disorders                    |
| <input type="checkbox"/> Hearing loss                               | <input type="checkbox"/> General fatigue                               | <input type="checkbox"/> Slurred speech                      |
| <input type="checkbox"/> Blurred vision                             | <input type="checkbox"/> Nausea  | <input type="checkbox"/> Unintelligible speech               |
| <input type="checkbox"/> Sensitivity to light                       | <input type="checkbox"/> Allergies                                     | <input type="checkbox"/> Slow reaction time                  |
| <input type="checkbox"/> Chronic headaches                          | <input type="checkbox"/> Skin rashes                                   | <input type="checkbox"/> Poor performance with timed tests   |
| <input type="checkbox"/> Hair loss                                  | <input type="checkbox"/> Excessive itching                             | <input type="checkbox"/> Skin irritation                     |

Thank you for filling in the questionnaire. The information may give your doctor vital information that he can use to help you improve you health. Please give this questionnaire to one of the doctor's staff.