Kinetic Patterns Inc.

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Name____ Age_____________
First Initial Last

Date of birth: day______month______year______ Hm Ph______________________Wk Ph____________________

Cell Phone_________________________Address____

City___________________________Postal Code_________________Occupation_____________________________

Contact person_________________________________Relation_________________Phone_____________________

Present Physician____________________________________Referred by___________________________________

Reason for visit____Email______________________________________

Main Complaints

Main Complaints	How Long
1	
2	
3	
4	

Medications (list all present medications and/or injections only - vitamins and other supplements on page 4)

Name	Strength	Dosage	How long
1			
2			
3			
4			
5			
6			
7			

Past Medical History (include important illness, operations, accidents, stress)

Problem	Year

Allergies or Reactions

Drugs, medicines: ____________________

Foods: ____________________

Medical Complaints

Please complete all areas of the questionnaire if you know the answers.

0 -none 1- some 2-severe **or** yes / no if applicable

Energy

Tired early in the day ______

Excessive tiredness by early evening ______

Weak muscles most of the time ______

Frequent feeling of too cold ______

Frequent feeling of too hot ______

Digestion

Eating more than is good for you ______

Poor Appetite ______

Change of weight more than 5lbs last yr. ______

Frequent heartburn or stomach pains ______

Cramps, bloating or gas after eating ______

Long standing diarrhea ______

Long standing vomiting ______

Long standing constipation ______

Change in bowel habits ______

Bleeding or very dark bowel movements ______

Hemorriods, rectal itching ______

Dental ______

Poor teeth, gums, dentures ______

Grinding teeth or painful jaw joint ______

Do you have mercury/amalgam fillings ______

Were your mercury fillings removed ______

Do you have root canals ______

Genito Urinary ______

Pain or discomfort passing urine ______

Difficulty starting or controlling urination ______

Frequent urination ______

2 or more urinations at night ______

3 or more urinary tract infections ______

Sexual difficulties / infertility ______

Women Only

Periods heavy or irregular ______

Cramps during period ______

Bloating or unwell before periods ______

Premenstrual headaches or irritability ______

Vaginal infections, irritation, discharge ______

Abnormal Pap test ______

Date of last Pap test ______

Number of pregnancies ______

Number of children ______

Menopause symptoms ____________________

____

Fibroids ______

Endometriosis ______

Birth control pills or hormone use ______

Osteoporosis or osteopenia ______

Environmental

Are you sensitive to perfumes ______

Sensitive to chemicals ______

Have you been exposed to chemicals ______

Respiratory

Shortness of breath ______

Shortness of breath while lying down only ______

Shortness of breath on physical exertion ______

Persistent cough or wheezing ______

Coughing phlegm or blood ______

Cardiovascular

Repeated tightness or pain in chest ______

Heart beating irregularly or very fast ______

High blood pressure ______

Dizziness, fainting ______

Head

Severe or frequent headaches ________

Convulsions, fits, epilepsy ________

Blackouts, collapse ________

Vision or eye problems ________

Ringing in the ears, deafness ________

Changes in taste or smell ________

Frequent sneezing or hay fever ________

Persistent or frequent colds ________

Sinus problems ________

Nose bleeds ________

Limbs

Aching joints, arthritis ________

Numbness, tingling, shooting pains ________

Repeated cramps or spasms in muscles ________

Painful varicose veins ________

Swelling of feet or hands ________

Cold feet or hands most of the time ________

Troublesome back pain ________

Troublesome neck pain ________

Skin

Dryness ________Oiliness______Acne________

Recurrent boils_______Itchiness/rash________

Hives________ Eczema/psoriasis________

Poor wound healing_______ Easy bruising________

Warts________Dandruff________Hair loss________

Excessive hair growth_________

Lumps or swelling under the skin ________

Lumps in the breast or nipple discharge ________

Excessive sweat or body odour ________

Halitosis or bad breath ________

Mental

Brain fog ________

Lack of ambition ________

Inability to make decisions ________

Feeling depressed, down, upset ________

Cannot fall asleep or frequent waking up ________

Disturbing dreams ________

Difficulty socializing ________

con't - Mental

Poor memory ________

Thoughts of suicide ________

Worrying often about health ________

Anxiety about little problems (often?) ________

Feeling that people want to harm you ________

Feeling uptight and anxious (often?) ________

Shaking or heavy breathing ________

Cannot trust people, doctors ________

Getting angry, fits of temper ________

Please specify the following

Are you or have you ever been anemic? ________

Were you born by caesarean section? ________

Were you born with a medical condition? ________

____

Do you have any surgical body parts? ie. hip heart valve, pacemaker, breast, other ________

____

____

What X-Rays, CT scans, or MRI, have you had

____

____

Is there any treatment you refuse because of your personal belief ____________________

Have you traveled to a tropical country? ________

Have you received blood transfusion(s)? ________

Have you been tested for AIDS? ________

Are you HIV Positive? ________

Have you tested positive for Hepatitis? ________

Diet

Do you eat breakfast? ________

How many meals do you eat in a day? ________

How may meals daily do you spend 20 minutes or more at a table? ____________________

Average number of cups or glasses per day:

Coffee_______Tea_______Pop_______

Milk _______Alcohol_______Water______

Do you smoke cigarettes?______how long? ________

How many years have you smoked?

con't - Diet

What is your weight __________ height __________

What foods & beverages do you crave strongly? ______________________________

Do you crave sugar or sweet food? __________

Stress

Do you have problems coping with marriage or friends? __________

Do you have excessive financial or job security problems? __________

Do you work under pressure? __________

Do you live / work irregular hours? __________

Do you frequently travel or commute long distance? __________

Do you regularly relax, meditate, pray practice yoga, tai-chi? __________

Exercise / Activity

Not much, sedentary __________

Moderate exercise __________

Active __________

Do you feel better after exercise? __________

Do you feel pains or tired after exercise? __________

For parents of patients 10 years of age and under

Was there difficulty with pregnancy, labour or delivery? ______________________________

Was the child breast fed & how long? __________

Problems with formula feeding? __________

Delayed developments? __________

Has the child had immunization shots? __________

Were there frequent infections? __________

Frequent antibiotics? __________

Poor eater_______Poor sleeper________

Spitting up_______Often crying_______

Bed wetting_______ Colicky_______

Rashes______

History of Family Illnesses	***Age***
Father:	
Mother:	
Brothers, sisters:	
Grandparents:	
Children:	
Other:	

Supplements - vitamins, minerals, herbs, etc.

Name	***Strength***	***Dosage***	***How long***
1			
2			
3			
4			
5			
6			
8			