

## ***FROM PAIN TO WELLNESS*** **WELLNESS QUESTIONNAIRE**

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

Today's Date \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
month day year

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Medical Insurance Carrier: \_\_\_\_\_

Secondary Medical Insurance Carrier: \_\_\_\_\_

Referring Physician (if you had): Name: \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician (must have): Name: \_\_\_\_\_ Phone \_\_\_\_\_

Name and phone number of any other physicians you are currently seeing: \_\_\_\_\_

Occupation: \_\_\_\_\_ Social Security#: \_\_\_\_\_

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**A) Expectations:**

What are you expectations for this evaluation?

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1. Please check appropriate box(es):

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

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
<b>Example:</b> Back pain	Moderate	Aleve	A little
a.			
b.			
c.			
d.			
e.			
f.			
g.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)

Example: Wendy, age 7, sister

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4. Do you have any pets or farm animals? Yes\_\_\_ No\_\_\_  
 If yes, where do they live? 1. \_\_\_ indoors 2. \_\_\_ outdoors 3. \_\_\_ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes\_\_\_ No\_\_\_  
 If so, when and where? \_\_\_\_\_

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6. Have you or your family recently experienced any major life changes? Yes\_\_\_ No\_\_\_  
 If yes, please comment: \_\_\_\_\_

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7. Have you experienced any major losses in life? Yes\_\_\_ No\_\_\_  
 If so, please comment: \_\_\_\_\_

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8. How important is religion (or spirituality) for you and your family's life?  
 a. \_\_\_ not at all important  
 b. \_\_\_ somewhat important  
 c. \_\_\_ extremely important

9. How much time have you lost from work or school in the past year?  
 a. \_\_\_ 0-2 days  
 b. \_\_\_ 3-14 days  
 c. \_\_\_ > 15 days

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10. Previous jobs:

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11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

- a. Did you feel safe growing up?  
 Yes       No
- b. Have you been involved in abusive relationships in your life?  
 Yes       No
- c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?  
 Yes       No
- d. Do you currently feel safe in your home?  
 Yes       No
- e. Do you feel safe, respected and valued in your current relationship?  
 Yes       No
- f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?  
 Yes       No
- g. Would you feel safer discussing any of these issues privately?  
 Yes       No

12. Past Medical and Surgical History:

<b>ILLNESSES</b>	<b>WHEN</b>	<b>COMMENTS</b>
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, convulsions, or seizures		
k. Gallstones		
l. Gout		
<b>ILLNESSES</b>	<b>WHEN</b>	<b>COMMENTS</b>

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m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		
	<b>INJURIES</b>	<b>WHEN</b>	<b>COMMENTS</b>
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	<b>DIAGNOSTIC STUDIES</b>	<b>WHEN</b>	<b>COMMENTS</b>
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Other (describe)		
	<b>OPERATIONS</b>	<b>WHEN</b>	<b>COMMENTS</b>
au.	Appendectomy		

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av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

13. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

14. How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

15. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

16. What medications are you taking now? Include non-prescription drugs.

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Are you allergic to any medications?

Yes \_\_\_ No \_\_\_

If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_

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17. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

18. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

19. As a child, were there any foods that you had to avoid because they gave you symptoms?  
Yes \_\_\_ No \_\_\_

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

20. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	

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	<b>Usual Breakfast</b>	√		<b>Usual Lunch</b>	√		<b>Usual Dinner</b>	√
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

21. How much of the following do you consume each week?

a. Candy	
b. Cheese	
c. Chocolate	
d. Cups of coffee containing caffeine	
e. Cups of decaffeinated coffee or tea	
f. Cups of hot chocolate	
g. Cups of tea containing caffeine	
h. Diet sodas	
i. Ice cream	
j. Salty foods	
k. Slices of white bread (rolls/bagels)	
l. Sodas with caffeine	
m. Sodas without caffeine	

22. Are you on a special diet?

- ovo-lacto                       vegetarian  
 diabetic                         vegan  
 dairy restricted                 blood type diet

Yes\_\_\_ No\_\_\_  
 \_\_\_ other (describe):  
 \_\_\_\_\_  
 \_\_\_\_\_

23. Is there anything special about your diet that we should know?

Yes\_\_\_ No\_\_\_

If yes, please explain:

\_\_\_\_\_

24. a. Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.?

Yes\_\_\_ No\_\_\_

b. If yes, are these symptoms associated with any particular food or supplement(s)?

Yes\_\_\_ No\_\_\_

c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

\_\_\_\_\_

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25. Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes\_\_\_ No\_\_\_

26. Do you feel much **worse** when you eat a lot of :

_____ high fat foods	_____ refined sugar (junk food)
_____ high protein foods	_____ fried foods
_____ high carbohydrate foods (breads, pastas, potatoes)	_____ 1 or 2 alcoholic drinks
	_____ other _____

27. Do you feel much **better** when you eat a lot of :

_____ high fat foods	_____ refined sugar (junk food)
_____ high protein foods	_____ fried foods
_____ high carbohydrate foods (breads, pastas, potatoes)	_____ 1 or 2 alcoholic drinks
	_____ other _____

28. Does skipping a meal greatly affect your symptoms? Yes\_\_\_ No\_\_\_

29. Have you ever had a food that you craved or really "binged" on over a period of time?  
 Food craving may be an indicator that you may be allergic to that food. Yes\_\_\_ No\_\_\_  
 If yes, what food(s)? \_\_\_\_\_  
 \_\_\_\_\_

30. Do you have an aversion to certain foods? Yes\_\_\_ No\_\_\_  
 If yes, what foods? \_\_\_\_\_

31. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

32. Intestinal gas: \_\_\_\_\_ Daily \_\_\_\_\_ Present with pain  
 \_\_\_\_\_ Occasionally \_\_\_\_\_ Foul smelling  
 \_\_\_\_\_ Excessive \_\_\_\_\_ Little odor

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33. a. Have you ever used alcohol? Yes\_\_\_ No\_\_\_  
 b. If yes, how often do you now drink alcohol? \_\_\_ No longer drinking alcohol  
 \_\_\_ Average 1-3 drinks per week  
 \_\_\_ Average 4-6 drinks per week  
 \_\_\_ Average 7-10 drinks per week  
 \_\_\_ Average >10 drinks per week  
 c. Have you ever been addicted to alcohol or drugs?  No  Yes  
 If yes, what type and for how long? \_\_\_\_\_  
 e. Have any of your family members been addicted to alcohol or drugs?  No  Yes  
 If yes, who and what type?
- 

34. Have you ever used recreational drugs? Yes\_\_\_ No\_\_\_
35. Have you ever used tobacco? Yes\_\_\_ No\_\_\_  
 If yes, number of years as a nicotine user \_\_\_\_\_. Amount per day \_\_\_\_\_. Year quit \_\_\_\_\_.  
 If yes, what type of nicotine have you used? \_\_\_ Cigarette \_\_\_ Smokeless  
 \_\_\_ Cigar \_\_\_ Pipe \_\_\_ Patch/Gum
36. Are you exposed to second hand smoke regularly? Yes\_\_\_ No\_\_\_
37. Do you have mercury amalgam fillings? Yes\_\_\_ No\_\_\_
38. Do you have any artificial joints or implants? Yes\_\_\_ No\_\_\_
39. Do you feel worse at certain times of the year? Yes\_\_\_ No\_\_\_  
 If yes, when? \_\_\_ spring \_\_\_ fall  
 \_\_\_ summer \_\_\_ winter
40. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes\_\_\_ No\_\_\_  
 If yes, which one(s)? \_\_\_ lead \_\_\_ cadmium  
 \_\_\_ arsenic \_\_\_ mercury  
 \_\_\_ aluminum

41. Do odors affect you? Yes\_\_\_ No\_\_\_

42. How well have things been going for you?

	<b>Very Well</b>	<b>Fair</b>	<b>Poorly</b>	<b>Very Poorly</b>	<b>Does not apply</b>
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

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	Never	Seldom	Sometimes	Frequently	Always
During the past month have you been tense or anxious?					
During the past month have you been depressed or discouraged?					
During the past month have you been irritable and upset?					
When you are in pain how often is your husband/wife/other family member supportive and encouraging?					
When you are in pain how often does your husband/wife/other family member ignore you or become angry?					

43. Have you ever had psychotherapy or counseling? Yes\_\_\_ No\_\_\_  
 Currently? \_\_\_\_\_ Previously? \_\_\_\_\_ If previously, from \_\_\_\_\_ to \_\_\_\_\_.  
 What kind? \_\_\_\_\_  
 Comments: \_\_\_\_\_

44. Are you currently, or have you ever been, married? Yes\_\_\_ No\_\_\_  
 If so, when were you married? \_\_\_\_\_ Spouse's occupation \_\_\_\_\_  
 When were you separated? \_\_\_\_\_ Never \_\_\_\_\_  
 When were you divorced? \_\_\_\_\_ Never \_\_\_\_\_  
 When were you remarried? \_\_\_\_\_ Never \_\_\_\_\_ Spouse's occupation \_\_\_\_\_  
 Comments: \_\_\_\_\_

45. Hobbies and leisure activities: \_\_\_\_\_  
 \_\_\_\_\_

46. Do you exercise regularly? Yes\_\_\_ No\_\_\_  
 If so, how many times a week? When you exercise, how long is each session?  
 1. \_\_\_\_\_ 1x 1. \_\_\_\_\_ ≤15 min  
 2. \_\_\_\_\_ 2x 2. \_\_\_\_\_ 16-30 min  
 3. \_\_\_\_\_ 3x 3. \_\_\_\_\_ 31-45 min  
 4. \_\_\_\_\_ 4x or more 4. \_\_\_\_\_ > 45 min  
 What type of exercise is it?  
 \_\_\_\_\_ jogging/walking \_\_\_\_\_ tennis  
 \_\_\_\_\_ basketball \_\_\_\_\_ water sports  
 \_\_\_\_\_ home aerobics \_\_\_\_\_ other \_\_\_\_\_

47. Sleep History:  
 Please indicate whether you have a sleep problem:  
 No sleep problem (Sleep well and wake up reasonably refreshed most of the time)  Mild problem (Up 3 times or less times at night for less than 15 minutes or wake up unrefreshed)  Moderate (Up three or more times at night for more than 15 minutes each time or wake up exhausted)  Moderately severe (Three hours sleep or less)  Severe (No sleep pattern, sleeping waking all day and night )

48. Functional History:  
 Please indicate accurately what things you are definitely unable to do because of your condition:

Activity	Able to do	Difficult but can do	Cannot do
Bathing Self			
Dressing Self			

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Toileting self			
Getting out of bed			
Walking			
Performing household chores			
Shopping or doing yard work			
Driving			
Working			
Doing recreational activities or hobbies			
Having sexual relations			
Physical exercise			
Socializing with friends and/or family			

How often during the day are you inactive because of your condition:?  Constantly (80-100% of the time)   
 Most of the time (50- 80% of the time)  Significantly (30-50% of the time)  Occasionally (less than 30% of the time)  None

What is your present maximum sitting/standing time and walking distance?

Sitting time:  No sitting problem  Mild problem (Have to get up after 2 hours or more)  Moderate (Have to get up after about an hour)  Moderately severe (Have to get up after about ½- ¾ hour)  Severe (Have to get up after 10-15 minutes or less)

Standing time:  No standing problem  Mild problem (Have to stop standing after 2 hours or more)  Moderate (Have to stop standing after about an hour)  Moderately severe (Have to stop standing after about ½- ¾ hour)  Severe (Have to stop standing after 10-15 minutes or less)

Walking distance:  No walking problem  Mild problem (Have to stop after 1 mile or more)  Moderate (Have to stop after ½- ¾ mile)  Moderately severe (Have to stop after a few blocks)  Severe (Have to after 1 block or less)

**49. Communication:**

Do you have difficulty with: Understanding?  Yes  No    Speaking?  Yes  No    Vision?  Yes  No  
 Hearing?  Yes  No    Please describe:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_