GOOD NATURED MEDICINE
IN DEPTH PATIENT QUESTIONNAIRE

Name:		How did you hear about us?	
Allergies to medications or other substances:			
Address:	Date of birth:	Height:	Weight:
Phone Number (day):	Occupation (adult):		
Education:			
Marital Status (circle one): Single Married Partnered Divorced Widowed Separated		Number of Children:	
Name of primary care physician or clinic:		Name(s) of mental health or other health care providers:	
IF CHILD, PARENTS OR GUARDIANS NAME(S):			
Mother/parent/guardian:		Father/parent/guardian:	
If parents are not living together, describe child's living situation:			

MAJOR HEALTH CONCERNS, IN ORDER OF IMPORTANCE FOR YOU: (USE ADDITIONAL PAGES IF NECESSARY.)

COMPLAINT	ONSET & FREQUENCY	CAUSES (KNOWN OR SUSPECTED)

ARE YOU CURRENTLY TAKING ANY MEDICATIONS OR HERBS/SUPPLEMENTS? (USE ADDITIONAL PAGES IF NECESSARY)

MEDICATION/SUPPLEMENT NAME	DATE STARTED & DOSAGE	REASON FOR THIS MEDICATION

WHAT OTHER TREATMENTS, DIETS OR REGIMES ARE YOU CURRENTLY FOLLOWING? (USE ADDITIONAL PAGES IF NECESSARY)

TREATMENT OR REGIME	SINCE	REASON / RESULTS

MEMBERS OF HOUSEHOLD (INCLUDING PETS)

NAME	AGE	RELATIONSHIP

402 NE 72nd St, Ste 3, Seattle 98115. Tel/fax: 206.686.5012

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD? MARK P FOR PAST AND C FOR CURRENT.

	Abscesses		**Cancer** Type:		**Gastric Reflux**		**Irritable Bowel Syndrome**		**Pneumonia**		**Trauma**
	Acne				**Gout**		**Kidney Disease**		**Post Traumatic Stress**		**Tuberculosis**
	Alcohol or drug abuse		**Cataracts**		**Hay Fever**		**Liver Disease**		**Prostate condition**		**Typhoid Fever**
	Allergies		**Chicken Pox**		**Headaches**		**Malaria**		**Psychiatric care**		**Ulcers**
	Addictions to:_____		**Chronic cough**		**Heart Murmur**		**#____ of Mercury Fillings**		**Rheumatic fever**		**Last date of Urinary tract infection:**
	Anemia		**Depression**		**Hepatitis ____**		**Memory problems**		**Sciatica**		
	Anxiety		**Diabetes____**		**Hernia**		**Measles**		**Sexual abuse**		**Recurrent vaginal infections**
	Appendicitis		**Eating Disorder**		**Herpes**		**Migraines**		**Skin conditions** Type:		**Whooping Cough**
	Arthritis		**Emphysema**		**High Blood Pressure**		**Mononucleosis**				**Yeast infections**
	Asthma		**Epilepsy**		**High Cholesterol**		**Mumps**		**STD's** Specify:		**Concerns for your personal safety?**
	Bleeding Disorders		**Gall stones**		**HIV positive**		**Night Sweats since _____**		**Stroke or Cardiovascular event**		**War veteran?**
	Breast lump		**Glaucoma**		**Hypoglycemia**		**Panic Attacks**		**Thyroid problems**		**Motor Vehicle Accident date:**
	Bronchitis		**Goiter**		**Insomnia**		**Parasites**		**Tonsillitis**		**Weight problems**

Any other major conditions?
Are there any of the preceding conditions that were more severe than usual or you have not fully recovered from? Explain.
What operations/hospitalizations have you had and when? Any complications?
What major injuries have you had and when? Any long-term effects?
List any substances you are allergic to and describe the reaction.
What vaccinations have you had? Any adverse effects?
Do you have breast implants or other foreign body parts (pacemaker)? Please list date of implant.
If you're currently under the care of another physician(s) please indicate treatments you've received & for what condition:
What was the date of your last… Physical exam? GYN or PROSTATE exam? Blood tests?

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT HAVE AFFECTED YOUR BLOOD RELATIVES:

Alcoholism	Bleeding Disorders	Epilepsy/Seizures	Kidney Disease	Schizophrenia
Allergies	Brain Tumors	Gonorrhea	Learning Disabilities	STDs (_____)
Anemia	Cancer (_____)	Gout	Mental Illness	Skin Conditions
Aneurysms	Cerebral Palsy	Hay Fever	Mental Retardation	Stroke
Anxiety	Chemical Dependency	Headaches	Migraines	Syphilis
Arthritis	Depression	Heart Disease	Muscular Disease	Thyroid Disease
Asthma	Diabetes (I__ or II__)	Hepatitis	Obsessive Compulsive DO	Tics
Bipolar Disorder	Eczema	High Blood Pressure	Paralysis	Tuberculosis

RELATIVE	AGE IF ALIVE	AGE AT DEATH	MAJOR AILMENTS/CAUSE OF DEATH
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Significant family deaths and their age at death, describe any particular losses had a great impact on you or your family:			

DIET / LIFESTYLE

How many meals do you eat per day?
Describe a typical day's diet. Include all meals, snacks and beverages and the times they are typically consumed.
How much water do you drink per day? Do you tend to be thirsty?
Other beverages? Describe.
Do you prefer hot, cold or room temperature beverages?
What foods do you avoid?
List symptoms caused by any particular foods or drinks.
List the foods you crave, regardless of their nutritional value (ex: sweets, chocolate, salty, sour, breads, rich/fatty, spicy, hot, cold, bitter):
How often do you have bowel movements per week? _____ Do you see any undigested food/blood/mucous in stool? _____ Straining? _____ Constipation? _____ Diarrhea? _____ Belching/Gas? _____ Bloating after meals? _____
How much of the following substances are you using regularly: Tobacco: Alcohol: Coffee: Recreational Drugs:

Have you lost or gained any weight in the last six months?	How many pounds?	By what method?
What exercise do you do?	Length of time?	Frequency?
What type of weather do you like and dislike? (temperate, mountain, seashore, desert)		
What things give you the most pleasure in life? Describe.		
What things give you the most displeasure? Describe.		
List any fears and phobias you may have: (claustrophobia, dark, thunderstorms, animals, water, heights, etc)		
How is your sleep?	What time do you go to bed?	
Do you have trouble falling asleep?	What keeps you up?	
Do you wake in the night?	What time(s) is/are typical?	
What time do you wake in the morning?	Do you wake feeling refreshed?	
What position do you sleep in?	Is there a position you cannot sleep in?	
Do you stay covered at night?	Do you stick your feet out from under the covers?	
What is your sense of your body temperature? Warm/cold	Your hands? Warm/cold	Your Feet? Warm/cold
When you are upset do you like to be consoled & how?	Do you like to be around other people?	
List any characteristic dreams you have now or had in the past. Include dreams which are/were vivid, recurrent or seemed important to you.		
What is the best time of day for you & why?		
What is the worst time of day for you & why?		
Are there any unique or peculiar patterns to your symptoms or life in general?		

OPTIONAL CHRONOLOGICAL TIMELINE (USE ADDITIONAL PAGES IF NECESSARY)

While not always apparent, your state of mental & physical health is influenced by, and influences, your life events. Jot down the timing of your main health concerns (from page 1), then, fill in the other column with what was of primary importance in your life at the time. Consider, for example, the following:

- Significant and recurrent illnesses
- Traumas and injuries, either physical or emotional
- Developmental and life milestones
- Medications used; surgeries; substance abuse
- **Specific strong memories**
- Important dates (e.g., moves, family stress, relationship changes, births, deaths, pets, etc.)

Age (or Year)	Change in Physical or Emotional Health	Life Events & Primary Goals