THE RIVERWALK GROUP

Tel. 203-329-3759
The Phillips Mansion
666 Glenbrook Rd, first floor
Stamford, CT 06906

ADULT QUESTIONNAIRE

PERSONAL INFORMATION:

First Name: _____ Last Name:_____ Middle Initial: _____

Home Address: _____ Phones: (Home) _____

_____ (Cell) _____

Email: _____ (Work) _____

Birth Date: ____/____/____ ___ Female, ___ Male SSN (optional): _____

Height: _____ Weight: _____ lbs

Occupation: _____

Referred by:_____

Current Diagnosis (list all) _____

OTHER:

Primary Care Physician:_____ Phone:_____

Fax #:_____ City, State:_____

GENERAL: Referred by: _____

Primary Complaint: _____

_____

Goals for the visit: _____

_____

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SPECIALISTS Include MDs. Naturopaths, Homeopaths, other therapists

NAME	SPECIALTY	PHONE NUMBERS	CITY, STATE	LAST VISIT

PAST MEDICAL HISTORY:

CONDITION	PAST TREATMENTS	CURRENT TREATMENTS	APPROXIMATE DATE (S) of TREATMENT

CURRENTMEDICATIONS, VITAMINS, MINERALS, and OTHER NUTRITIONAL SUPPLEMENTS:

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EARLY HEALTH HISTORY:

Did your mother have any known problems during her pregnancy with you (illness, stress, medications, smoking, vaccines, alcohol)?_____

_____

_____

Were you breastfed or bottlefed? If breastfed, please indicate duration_____

_____

Did you have any significant stresses in childhood or adolescence? If yes, please explain _____

_____

_____

Please check if you had any of the following childhood illnesses?

___ Frequent Ear, Throat or other Infections ___Colic ___Reflux ___Meningitis ___Thrush

___Asthma ___Chicken Pox ___Eczema ___Frequent Colds ___Other_____

Did you take ____antibiotics or _____ steroid medications frequently?

Did you receive standard childhood immunizations?_____

Did you ever have adverse reactions to vaccines? If yes, please explain_____

FEMALE SPECIFIC INFORMATION

Age at first period _____ Date of last period _____ Length of cycles_____

History of irregular/abnormal periods? ___Yes, ___No If yes, please describe:_____

_____

Please check if you have a history of ___Endometriosis____Fibroids____Polycystic Ovarian Syndrome?

Describe any premenstrual symptoms _____

_____

Are you taking birth control pills? _____ If yes, for how long?_____ If no, have you ever taken them?_____

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Any known history of Infertility problems? _____ If yes, please explain_____

_____

Pregnancies: None_____ Term Births_____ Miscarriages_____ Abortions_____

Are you currently pregnant?_____ If so, what is your due date?_____

Illnesses or complications during pregnancy or labor and delivery

_____

Medications taken during pregnancy or labor and delivery_____

If you have ever had a C-Section, please explain_____

Any complications for you after delivery_____

Any history of breast problems (tenderness, cysts, etc)?_____

Any history of yeast infections? If yes, please explain_____

FAMILY HISTORY:
List any allergies,major illnesses, genetic diseases or problems (such as digestive issues or mental health problems) for each family member.

Mother _____

Father _____

Maternal Grandparents _____

Paternal Grandparents _____

Other _____

SOCIAL and LIFESTYLE HISTORY:

With whom do you live? Include children, parents, relatives, friends, etc and their ages.

_____

_____

Recent changes, major losses, births, deaths, divorce, remarriage, moves, etc._____

_____

How many hours of SLEEP per night do you average?_____ Any difficulty falling asleep or waking up?_____

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Quality of sleep? _____

_____

EXERCISE: ___None Type_____ Frequency_____

Recent TRAVEL (location, duration, vaccines prior to travel or illnesses during/after that you think relate to the travel):

_____

_____

_____

ALCOHOL: ___Never If yes, frequency_____ Any alcoholics in your family?_____

TOBACCO: ___Never ___Smoked or ___Smoking ____ packs/day from age _____ to _____.

If still smoking, have you ever tried to quit? ____ What methods?_____

What are your general EATING HABITS (overeat, undereat, picky, etc)?_____

Have you been on any diets? Please explain (including results and patterns of loss and gain)_____

_____

Have you ever had an eating disorder? If yes, which one(s)?_____

DIETARY/NUTRITIONAL/DIGESTIVE HISTORY:

Are you currently following a special diet? Please explain_____

_____

Known food allergies_____

Suspected food SENSITIVITIES_____

Food CRAVINGS (e.g. bread, pasta, cheese, salty foods, sodas/coffee/tea with or without caffeine, alcohol, milk, etc):

_____

STOOL pattern (frequency, color, odor, consistency)_____

_____

Do you or have you ever had gastrointestinal problems? Please Describe_____

_____

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Please list the foods and beverages normally consumed by you in a typical three day period.

DAY 1

Breakfast	
Morning Snack (s)	
Lunch	
Afternoon Snack (s)	
Dinner	
Other	

DAY 2

Breakfast	
Morning Snack (s)	
Lunch	
Afternoon Snack (s)	
Dinner	
Other	

DAY 3

Breakfast	
Morning Snack (s)	
Lunch	
Afternoon Snack (s)	
Dinner	
Other	

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ENVIRONMENTAL/ALLERGY HISTORY:

LOCATION: ____City ____Suburban ____Wooded ____Farm ____Other_____

WATER: ___City ____Well If you have a purification system, please describe_____

Type of HEAT: ____Electric ____Gas ____Oil ____Other_____

Do you live near: ____Power lines ____Woods ____Industrial areas ____Water Type (ocean, swamp, etc)_____

Does your home have a lot of: ____Dust ____Mold ____Down/Feather items (pillows, stuffed animals, etc)

Are there specific areas in your home that you suspect have issues? Please describe_____

_____

Bedding: ____Synthetic ____Down ____Feather ___Mattress cover

Flooring: ____Wall-to-Wall Carpet ____Area rug ___Wood ___Glued down ____Synthetic Pad

Any known exposure to harmful chemicals?_____

Do you have any known ALLERGIES to food and/or medications? If yes, please list names and describe reactions:

_____

_____

CHECK WHERE APPROPRIATE:

___ Tick infested area ___ Tick found on household pets
___ Frequent outdoor activities ___ Vacation to high risk area ___ Hiking, fishing, camping or hunting
___Other household members with tick exposure and/or Lyme ___ Gardening

Are you sensitive to any of the following? Check where appropriate.

____Perfumes/Cosmetics ____Cleaning Products ____Mold ____Paint

____Pollens/Grasses ____Soaps ____Animals (dander)

____Detergents ____Dust ____Gasoline ____Tobacco Smoke

____Other→Please Describe_____

Are there foods that you avoid because of how they make you feel? Explain_____

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Please mark which tests have been done and provide date and results.

EVALUATION—TEST	**DATE**	**RESULTS (Normal, Abnormal)** ***** Please send results/reports with this form *****
Blood Chemistry (Including Liver Function Tests)		
Blood Count (CBC)		
IgG Food Sensitivity Panel		
IgE Environmental Allergy Panel		
EKG		
EEG		
Hair Elements		
Urine Toxic Metals and Elements		
Homocysteine		
Folic Acid		
Serum—Methylmalonic Acid		
Immune Profile		
Urine—Organic Acids		
Amino Acids		
Plasma or Serum Zinc		
Plasma or Serum Copper		
RBC Elements		
Iron Studies (Ferritin, % Iron Saturation, TIBC, etc)		
Thyroid Panel (TSH, etc)		
Serum Vitamin Levels (Specify)		
Stool Culture		
Stool Ova and Parasites		
Uric Acid (blood or urine)		
OTHER		

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Please list THERAPIES you have used or are using now…and check the appropriate RESPONSE you had.

NOW	PAST	THERAPY	Good	None	Bad	Comments
		Acupuncture				
		Psychiatrist				
		Homeopathy				
		Naturopathy				
		Occupational Therapy				
		Physical Therapy				
		Psychologist				
		Craniosacral				
		Energy Therapy				
		OTHER				

CURRENT SIGNS + SYMPTOMS: Please check where appropriate. Leave row blank if not applicable.

DESCRIPTION	MILD	MODERATE	SEVERE	DETAILS
Fatigue				
Difficulty falling asleep				
Difficulty staying asleep				
Nighttime waking				
Night walking				
Nightmares				
Fever				
Heat intolerance				
Cold intolerance				
Flushing				
Headache – Specify type				
Distorted senses – Specify if Vision, hearing, taste, smell				
Low self esteem				
Trouble remembering				
Seizures				

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Anxiety				
Irritability				
Depression				
Panic Attacks				
Dizziness				
Fainting				
Difficulty with concentration				
Difficulty with balance				
Numbness/Tingling				
Mood swings				
Conjunctivitis				
Ear ringing				
Hearing loss				
Sensitive to lights or loud noises				
Sore throats				
Congestion				
Dark circles/ puffiness under eyes				
Sinus infections				
Post nasal drip				
Loss of smell				
Loss of taste				
Bad breath				
Nose bleeds				
Hoarseness				
Cough—Dry				
Cough—Productive				
Wheezing				
Seasonal Allergies				
Heart Attack				
Muscle cramps				
TMJ problems				
Chest tightness				
Muscle weakness				
Muscle stiffness				
Joint stiffness				
Joint pain				
Poor appetite				
Bad teeth				
Gum bleeding				
Dry mouth				
Geographic tongue (map-like rash on the tongue)				
Cold sores				
Cracking at corner of lips				
Heartburn				
Nausea				
Vomiting				
Abdominal pain				
Bloating				
Belching				

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Diarrhea				
Constipation				
Undigested food in stool				
Mucous in stool				
Blood in stool				
Hemorrhoids				
Difficulty swallowing				
Eczema				
Hives				
Rash				
Athletes foot				
Acne				
Easy bruising				
Ears get red				
Sensitive to bug bites				
Pale skin				
Dry skin				
Itchy skin				
Cracking or peeling of feet				
Cracking or peeling of hands				
Nail biting				
Soft nails				
White spots on nails				
Thickening of nails				
Fungus on nails				
Ridges on nails				
Pitting of nails				
Urinary urgency				
Urinary leaking				
Urinary pain				
Urinary hesitancy				
Bed-wetting				
Kidney stones				
Blood in urine				
Prostate enlargement				
Jock itch				
Vaginal discharge				
Vaginal itching				
Post-Menopausal bleeding				
Tics				
Night blindness				
Gum disease				
Dry lips				
Teeth grinding				
Tremors				
Psoriasis				
Strong body odor				
OCD behavior				
Reflux				
Thrush				

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Please check any symptoms you experience

B complex
__Insomnia
__Dermatitis, patchy skin
__Fatigue
__Sugar craving
__Irritability, depression

Thiamin
__Anxiety, Fear
__Sleep disturbance
__Irritability
__Poor coordination
__Increased Alcohol/sushi
__swelling

B2 (riboflavin)
__Neuropathy
__dermatitis
__lack of taste, stomatitis
__Cracked lips
__watery or bloodshot eyes

B3(Niacin)
__abdominal discomfort
__Nausea or diarrhea
__Depression,
__poor memory, confusion
__rough skin
__canker sores
__bad breath

B5 (pantothenic acid)
__Fatigue
__burning or numb feet
__cramps, abdominal distress
__acne
__poor coordination
__hair loss

B6
__acne
__dermatitis,
__muscle weakness
__irritability, depression
__p__Poor immunity
__tooth decay
__fatigue
__Oxalates
__Anemia

Folic Acid
__Fatigue
__diarrhea
__sulfa drugs
__anemia

B12
__Poor memory
__vegetarian diet
__Viral infection, shingles
__depression
__poor balance

Biotin
__muscle pain
__depression
__hair loss
__dermatitis

Calcium
__brittle nails
__cramps
__depression
__tooth decay
__insomnia
__high soda intake

Choline/Inositol
__Depression
__Memory loss
__fat intolerance

Chromium
__anxiety
__fatigue
__poor glucose control

Copper
__anemia
__depression
__diarrhea
__fatigue
__hair loss
__bruising

Copper excess
__anxiety
__ringing in ears
__sensitive to metals
__poor concentration

Iodine
__Fatigue
__weight gain
__hypothyroidism
__dry skin and hair
__puffy face
__poor memory

Iron
__Anemia
__Brittle nails
__Confusion, poor memory
__Headaches
__Mouth/tongue sores
__Fatigue

Magnesium
__constipation
__muscle spasms
__insomnia
__anxiety
__hyperactivity
__restless leg
__teeth grinding
__headache/migraine

Manganese
__dizziness
__ringing in ears
__poor glucose control
__Seizures
__Mottled skin tone

Molybdenum
__Acne
__PMS
__Migraines
__Caffeine intolerance

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__sulfite/nitrite intolerance

Potassium
__Diarrhea
__edema
__difficulty breathing
__muscle cramps

Selenium
__Fatigue
__pancreatic insufficiency
__immune impairment

Sodium
__Cramps
__constipation
__PMS, morning sickness

Zinc
__Acne
__brittle nails
__depression
__delayed puberty
__poor growth
__hair loss
__impotence/infertility
__poor appetite
__low stomach acid
__Poor immunity
White spots on nails

Vitamin A
__Night blindness
__acne
__CF
__dry skin/hair
__infertility
__URI
__poor growth

Vitamin C
__bleeding gums
__easy bruising
__poor wound healing
__loose teeth
__Wrinkled skin
__joint pain

Vitamin D
__burning mouth
__diarrhea
__insomnia
__seasonal depression
__psoriasis
__scalp sweating
__poor coordination

Vitamin E
__altered gait
__poor reflex
__CF, Infertility
__dry, itchy skin
__breast cysts

Vitamin K
__bleeding ulcers
__nose bleeds, bruising
__liver or kidney disease

Essential Fatty Acids
__Dry, flaky skin
__cracking peeling hands/feet
__clear bumps on upper arms
__dandruff/cradle cap
__splitting, dull nails
__ear wax
__acne
__excess thirst
__poor attention

Pyroluria
__Poor dream recall
__white spots on nails
__skips breakfast
__sensitive to lights/noise
__histrionic/argumentative
__likes spicy foods

Poor liver function
__sensitive to perfumes, chemicals, cigarettes
__headaches/migraines
__poor appetite

Gluten intolerance
__low iron
__loose, unformed stools
__abdominal bloating
__floating stools
__itchy skin, psoriasis

Candida
__Thrush
__antibiotic use
__chronic congestion
__poor concentration
__bloating, gassiness
__sugar cravings
__eczema, psoriasis
__attention problems
__anal itching

Parasites
__abdominal bloating or discomfort
__food sensitivities
__tooth grinding
__psoriasis, eczema, hives
__fatigue
__anal itching
__loose/foul stools

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Do you have any dental amalgams? If so, how many?_____

Describe any other symptoms you would like us to know about you?

List any other history, pertinent thoughts or questions you want to address:
