Choose The Natural Path LLC

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Initial Visit Questionnaire

Please do your best to answer as completely as you can. The more honest you are, the more I can do to help you! ***Bring the completed forms and every medication and supplement you take to your appointment.*** All information is confidential and will ONLY be shared with your consent.

Date: ____________________

Name: ____

Gender: (*circle one*) Male / Female Date of Birth: ____/____/_________

Age: ____ Height: _________ Weight: ___________ lbs

Marital Status: (circle one) Single / Married / Divorced / Widowed

Are you disabled in any way? If so, please describe:

____

What concerns have motivated you to come see Dr. Sue?

____

____

____

____

*Forgive me! We have some background information we **MUST** collect.*

Know that I appreciate your patience!

Social History

Please describe your home environment. Who lives with you? Do you feel safe there?

____

____

____

Are you currently working? (*circle one*) Yes / No

Occupation? ____

Do you feel stressed? (*circle one*) Yes / No

Why? What do you do to alleviate stress?

____

____

Have you ever used tobacco products? (*circle one*) Yes / No

Are you still using? (*circle one*) Yes / No

Circle all that apply:

Cigar / Pipe / Cigarettes / Chewing / Vapor / Other ___________________

# of packs per day: _________ X # of years as a smoker _________== # Pack years_________

How many servings of *caffeine* do you consume daily? (this includes coffee, tea, sodas, energy drinks, etc): ______________

How much *alcohol* do you consume? Daily: ________ Weekly: __________

Do you use any other *recreational drugs*? (*circle one*) Yes / No

If "Yes," which ones? ____

Do you exercise? (*circle one*) Yes / No

What types of exercise do you do? How long per day?? How frequently?

____

____

Dietary History

Describe a normal day's intake to me. Please indicate the usual time of the meal too.

____AM Breakfast: ____

____PM Lunch: ____

____PM Dinner: ____

Snacks (when and what):

____

____

Water (what kind & how much): ____

Other beverages: ____

____

On average, how many times a week do you eat at a restaurant? _____ times per week

Any fast food? _______ times per week

Do you crave anything? (hot or cold drinks, chocolate, peanut butter, breads, sweets, alcohol, other)

____

What foods do you have trouble with/avoid? Why?

____

____

____

Important Bodily Functions

How much sleep do you get per 24-hours? __________ Bedtime?________ When you rise?_________

Is it deep and restful? (*circle one*) Yes / No

Do you wake at night? (*circle one*) Yes / No / Sometimes

Why? ____

Describe your energy level to me: ____

____

How often do you have a bowel movement? _______________

Are they easy to pass? Please describe any issues:

____

Do you use laxatives, fiber, stool softeners, or enemas?

____

Family Medical History

Has any blood relative ever had:

☐ Alcoholism	☐ Cancer	☐ Miscarriages
☐ Allergies	☐ Depression	☐ MTHFR
☐ Alzheimer's	☐ Diabetes	☐ Seizures Tuberculosis
☐ Asthma	☐ Heart attack before age 55	☐ Stroke
☐ Autism	☐ Heart Disease	☐ Suicide
☐ Bleeding disorder	☐ High Blood Pressure	☐ Tuberculosis
☐ Blood Clots	☐ Mental Disorder	☐ Other_________________

	Age	Medical conditions	Age at & cause of death
Father's Mother			
Father's Father			
Mother's Mother			
Mother's Father			
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			

Any blood related **Aunt** or **Uncle** with significant medical conditions?

____

____

Your Personal Medical History

Are you allergic to: (*please list*)

Drugs? ____

Foods? ____

Other? ____

Have you received any blood transfusions? (*circle one*) Yes / No   Year: __________

Immunizations: (*indicate year received if known*)

__________ COVID

__________ Flu

__________ Hepatitis B

__________ MMR

__________ Pertussis

__________ Pneumovax Tetanus (dT)

__________ Tetanus (dT)

__________ Zostavax

Others: ____

Surgical history:

YEAR	PROCEDURE

Please check all the Medical Conditions or Diagnoses you currently have or have had:

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bone or Joint Problems
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Colitis
- ☐ Constipation
- ☐ COVID
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Edema
- ☐ Emphysema /COPD
- ☐ German Measles
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infections of any kind (Lyme, Yeast, etc)
- ☐ Kidney Disease or Stones
- ☐ Leg Cramps
- ☐ Liver Disease or Jaundice
- ☐ Menopause
- ☐ Pleurisy
- ☐ PMS
- ☐ Pneumonia
- ☐ Prostate Enlargement
- ☐ Rheumatic Fever
- ☐ Seizures/Epilepsy
- ☐ Skin Disorders
- ☐ Stroke
- ☐ Syncope or Vertigo
- ☐ Syphilis or STD
- ☐ TB/Lung Disease
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Other: ____

List all current prescription medications:

____

____

____

List of all OTC vitamins, supplements, homeopathics, herbs, etc., that you currently use and why:

____

____

____

____

If you are a **female**, please answer the following:

Date of last menstrual period:____/____/__________

How long does bleeding last? ______days

How many days between periods?? _______________

Do you experience cramping? (*circle one*) Yes/No Heavy Bleeding? (*circle one*) Yes/No

Date and result of last GYN/pelvic exam: ____

Date and result of last mammogram: ____

Are you or could you be pregnant? (*circle one*) Yes / No

How many times have you been pregnant? _________

The results of those pregnancies:

1. First Pregnancy:
   a. Live birth? (*circle one*) Yes / No
   b. Full term or Premature? (*circle one*)
   c. Miscarriage? (*circle one*) Yes / No
2. Second Pregnancy:
   a. Live birth? (*circle one*) Yes / No
   b. Full term or Premature? (*circle one*)
   c. Miscarriage? (*circle one*) Yes / No
3. Third Pregnancy:
   a. Live birth? (*circle one*) Yes / No
   b. Full term or Premature? (*circle one*)
   c. Miscarriage? (*circle one*) Yes / No
4. Fourth Pregnancy:
   a. Live birth? (*circle one*) Yes / No
   b. Full term or Premature? (*circle one*)
   c. Miscarriage? (*circle one*) Yes / No

Have you had an abortion(s)? (*circle one*) Yes / No