

**Farah Ganjei Gron, C. Hom, FHom**  
**Child/Adult New Patient Questionnaire**

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**MAIN PROBLEM**

**1. What is the Chief Complaint (main problem) you are coming in for today?**

**2. When did this problem begin? What happened in your life around that time? What do you think caused it?**

**3. What aggravates the problem (certain types of food or weather, movement, light, noise, heat/cold, or anything else you can think of)?**

**4. At what time of the day or night is the problem the worst? Specify an**

hour if you can.

5. What symptoms can you identify that accompany the problem?

**WOMEN**

6. Number of pregnancies \_\_\_\_\_ number of children \_\_\_\_\_ number of miscarriages \_\_\_\_\_ number of abortions \_\_\_\_\_

7. At what age did menses (period) begin?                      If you have gone through menopause, at what age?

8. How frequently does (or did) your period come?

9. What about the duration, abundance, color, time of day when flow is greatest, any odor or clots?

10. How do you (did you) feel before, during and after menses? Any PMS symptoms?

**HEALTH HISTORY**

II. Frequency of bowel movements (BM):                      if you don't have a BM, do you use a laxative?

- 12. How frequently do you get colds and flus?**
- 13. Have you had any childhood illnesses twice, or in a very severe form, or after puberty?**
- 14. Have you had vaccinations since the standard childhood ones? Have you ever had an adverse reaction or unusual reaction to vaccinations?**
- 15. Have you had any surgery? What type and when?**
- 16. What other medical problems/diagnoses have you been treated for?**

**FAMILY HISTORY**

- 17. List Mental diseases, physical diseases, causes and ages of death of parents, siblings and grandparents on both sides.**

**Brothers/sisters:**

**Parents:**

**Mother:**

**Father:**

**Grandparents--Maternal:**

**Mother:**

**Father:**

**Grandparents--Paternal:**

**Mother:**

**Father:**

**18. List or give sheet of present medications you are taking—tell us to the best of your knowledge the reason you were prescribed this medication. How long have you been taking each medication?**

**19. List any supplements (vitamins) and herbs you are taking or give a sheet with them and tell us to the best of your knowledge why you are taking them and how long you have been taking them.**

**20. Are you presently on any Homeopathic remedies? If so, which one and what is the potency, dose and how often do you take it? Have you had any adverse reactions/aggravations to any remedies?**

**21. Is there anything else you want Farah to know about?**