

PATIENT DIAGNOSTIC QUESTIONNAIRE



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Name _____ How old are you? _____ Today's Date _____
How much do you weigh? (001) _____

YOUR CHIEF COMPLAINTS

Please mark with an (X) the principle or major conditions which you are concerned about, would like eliminated, or desire treatment for:

- | | |
|-----------------------------------|--------------------------------------|
| 002 () Overweight | 018 () Headaches |
| 003 () Underweight | 019 () Female Problems |
| 004 () Sexual Problems | 020 () Extreme Fatigue |
| 005 () Menopause Problems | 021 () Cancer |
| 006 () Heart Condition | 022 () Circulatory Problems |
| 007 () Blood Pressure Problems | 023 () Lung and/or Breathing |
| 008 () Digestion Trouble | 024 () Stomach and/or Gall Bladder |
| 009 () Gall Bladder Problems | 025 () Intestine or Bowel Troubles |
| 010 () Diabetes Mellitus | 026 () Neck and/or Spine Problems |
| 011 () Skin Disorder | 027 () Eye Condition |
| 012 () Ear or Hearing Disorder | 028 () Nose/Throat/Mouth Problems |
| 013 () Sinus Infections | 029 () Dizziness/Balance Disorder |
| 014 () Nervous/Emotional Trouble | 030 () Kidney/Bladder/Urinary |
| 015 () Allergies to Food | 031 () Allergies in General |
| 016 () Nutritional Evaluation | 032 () Thorough Diagnostic Checkup |
| 017 () Arthritis/Rheumatism | 033 () Alcohol or Tobacco Addiction |

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY WHEN COMPLETING THIS QUESTIONNAIRE:

Read each question carefully and mark with an (X) only those statements which are true for you (a yes answer).

If a question does not apply to you, or you do not recognize the terminology or disease, or if you are not sure and have a doubt about a question, then do not check the box, simply leave it blank ().

GENERAL

- 034 () Are you overweight?
- 035 () Are you underweight?
- 036 () Are your fingernails ridged or have white spots?
- 037 () Do you sleep less than seven hours per night?
- 038 () Do you rarely exercise?
- 039 () Do you smoke over 9 cigarettes each day or inhale pipe/cigars?
- 040 () Do you drink alcoholic beverages each day?
- 041 () Do you usually drink less than 8 glasses of water each day?
- 042 () Are you sensitive to chemicals, paint, exhaust fumes, cologne?
- 043 () Are you unable to recall your dreams the next day?

EYES

- 044 () Are you near sighted (can't see things a distance)?
- 045 () Are you far sighted (can't read small print without glasses)?
- 046 () Do your eyes frequently itch?
- 047 () Do you suffer from cross eyes?
- 048 () Do you have or have you had cataracts?
- 049 () Do you experience pain in your eyes?
- 050 () Are your eyes bloodshot?
- 051 () Do your eyes water?
- 052 () Do your eyes feel gritty?
- 053 () Is your vision blurred?

EARS

- 054 () Are you hard of hearing?
- 055 () Are you experiencing any discharge from your ears?
- 056 () Do you have ringing or noises in your ears?
- 057 () Do you suffer from recurrent ear infections?
- 058 () Do you have a punctured ear drum?

PATIENT DIAGNOSTIC QUESTIONNAIRE (cont'd)

MOUTH and THROAT

- 059 () Is your tongue badly coated?
060 () Do you have bad breath?
061 () Do you suffer from sores or cracks at corners of mouth?
062 () Do you frequently experience canker sores (sore mouth)?
063 () Are your gums sore?
064 () Do you frequently suffer from fever blisters?
065 () Do your gums bleed when you brush your teeth?
066 () Do you have sore throats frequently?
067 () Are your glands often swollen?
068 () Do you suffer from toothaches?
069 () Is your mouth often dry?
070 () Do you have excessive saliva?
071 () In the mornings do you have a bitter taste in your mouth?
072 () Do you frequently have a sore tongue?

RESPIRATORY

- 073 () Do you have frequent colds?
074 () Do you suffer from nasal polyps?
075 () Do you often have sinus infections?
076 () Do you experience night sweats?
077 () Do you have hay fever?
078 () Do you wheeze?
079 () Do you have Asthma?
080 () Do you experience difficulty in breathing?
081 () Do you have a chronic cough?
082 () Do you spit up phlegm?
083 () Do you spit up blood?
084 () Do you have spells of sneezing?
085 () Is your nose frequently stuffy?
086 () Does your nose run constantly?
087 () Do you have frequent nose bleeds?
088 () Do you catch severe colds?
089 () Do you have a chronic chest condition?
090 () Do you have post nasal drip?

CARDIOVASCULAR

- 091 () Do you have high blood pressure?
092 () Do you have low blood pressure?
093 () Do you have pains in the heart or chest?
094 () Are you troubled with blood clots?
095 () Do you have cold hands?

- 096 () Are your feet frequently cold?
097 () Do you have varicose veins?
098 () Are your ankles frequently swollen?
099 () Do you have an unusually slow pulse rate?
100 () Do you experience spells of rapid heart beat?
101 () Are you aware of your heart skipping beats?
102 () Do you experience shortness of breath while sitting still?
103 () Do you suffer from leg cramps after retiring to bed?
104 () Do you suffer from leg cramps during the day?
105 () Do you experience pain in your leg/hips when walking?

GASTROINTESTINAL

- 106 () Is your appetite poor?
107 () Do you have excessive hunger?
108 () Do you experience fainting spells when hungry?
109 () Does eating relieve fatigue?
110 () Do you feel shaky when hungry?
111 () Are you frequently drowsy after eating a meal?
112 () Do you eat when nervous?
113 () Do you frequently have diarrhea?
114 () Do you have difficulty in swallowing?
115 () Do you vomit frequently?
116 () Are you frequently nauseated?
117 () Are you bloated after eating?
118 () Do you have abdominal gas?
119 () Does eating greasy foods cause you to have indigestion?
120 () Do you belch or burp after eating?
121 () Do you have: indigestion immediately upon eating?
122 () indigestion within 1 hour after meals?
123 () indigestion 2 hours or more after meals?
124 () Do you have loose bowel movements?
125 () Have you ever had intestinal worms?
126 () Do you have pale or yellow colored stool?
127 () Do you suffer from constipation?
128 () Do you have one or less bowel movements daily?
129 () Are your stools bloody?

PATIENT DIAGNOSTIC QUESTIONNAIRE (cont'd)

- 130 () Do you have black tarry stools?
- 131 () Do you use laxatives?
- 132 () Do you suffer from severe abdominal pains?
- 133 () Do you have hemorrhoids (piles)?
- 134 () Do you have stomach ulcers?
- 135 () Do you have gall bladder disease?
- 136 () Do you have liver disease?

NEUROMUSCULAR

- 137 () Do you have neck pain?
- 138 () Do you have pain between the shoulders?
- 139 () Do you suffer from low back pain?
- 140 () Do you have swollen joints?
- 141 () Do you have a spinal curvature?
- 142 () Do you suffer from muscle spasms?
- 143 () Are your muscles frequently sore?
- 144 () Do you have muscle weakness?
- 145 () Are your joints stiff in the morning?
- 146 () Do you have shoulder/arm pain?
- 147 () Do you suffer from leg pain at rest?
- 148 () Do you have rheumatism?
- 149 () Does any part of your body experience numbness/tingling?
- 150 () Do you have frequent headaches?
- 151 () Are you often dizzy?
- 152 () Do you frequently feel faint?
- 153 () Do you have epilepsy?
- 154 () Do you bite your nails badly?
- 155 () Do you stutter or stammer?
- 156 () Are you a sleep walker?
- 157 () Do you have rheumatoid arthritis?
- 158 () Do you have osteoarthritis?
- 159 () Do you suffer from motion sickness?

FEET

- 160 () Do you suffer from painful feet?
- 161 () Do you have frequent foot cramps?
- 162 () Do you have plantar warts?
- 163 () Do you have heel spurs?
- 164 () Are you troubled with corns?

SKIN

- 165 () Is your skin tender?
- 166 () Does your skin itch?

- 167 () Do you have skin eruptions?
- 168 () Is your skin rough, especially on the back of your arms?
- 169 () Do you have Psoriasis?
- 170 () Do you bruise easily?
- 171 () Do you have Acne?
- 172 () Are you troubled with boils?
- 173 () Do you have Eczema?
- 174 () Are you aware of moles which are changing in size or color?
- 175 () Do you frequently experience goose bumps?
- 176 () Do you have hives (allergy reaction of the skin)?
- 177 () Do you have excessive perspiration?
- 178 () Do you get sores that are slow to heal?

URINARY

- 179 () Do you have frequent urination?
- 180 () Do you awaken at night to urinate?
- 181 () Are you a bed wetter?
- 182 () Do you dribble when sneezing or laughing?
- 183 () Have you ever lost control of your bladder?
- 184 () Do you have painful urination?
- 185 () Do you have blood in your urine?
- 186 () Are you troubled by urgent urination?
- 187 () Do you have difficulty in starting the stream?
- 188 () Do you have frequent bladder infections?
- 189 () Do you have frequent kidney infections?
- 190 () Do you have kidney stones?

ENDOCRINE

- 191 () Do you have excessive thirst?
- 192 () Do you frequently feel cold?
- 193 () Do you frequently feel hot?
- 194 () Are you unusually tired most of the time?
- 195 () Are you unusually jumpy or nervous?
- 196 () Is your hair coarse?
- 197 () Is your skin coarse?
- 198 () Are you diabetic?
- 199 () Do you get lightheaded when standing quickly?

FOR WOMEN ONLY

- 200 () Do you have painful periods?
- 201 () Do you have an excessive flow?
- 202 () Do you have irregular cycles?
- 203 () Do you suffer from menstrual cramps?
- 204 () Do you have hot flashes?
- 205 () Do you have vaginal discharge?
- 206 () Do you have a bloody spotting discharge?
- 207 () Have you had a hysterectomy?
- 208 () Do you retain fluid during your periods?
- 209 () Have you ever miscarried?
- 210 () Do you have Acne worse at menstruation?
- 211 () Do you have tender breasts?
- 212 () Do you have frequent yeast infections?
- 213 () Do you have lumps in your breasts?
- 214 () Do you have heavy hair growth on face or body?
- 215 () Do you take birth control pills?
- 216 () Do you have pre-menstrual depression?
- 217 () Is intercourse painful for you?
- 218 () Do you have a diminished sex desire?
- 219 () Do you have poor or infrequent orgasm?

- 236 () Are you afraid to eat anywhere except at home?
- 237 () Are you unhappy when others are happy?
- 238 () Are you usually unhappy and depressed?
- 239 () Do you often cry?
- 240 () Are you frequently miserable or blue?
- 241 () Do you sometimes wish you were dead and away from it all?
- 242 () Are your feelings easily hurt?
- 243 () Does criticism always upset you?
- 244 () Do people usually misunderstand you?
- 245 () Do you have to be on guard even with your friends?
- 246 () Do people often annoy you?
- 247 () Are you easily angered?
- 248 () Do you frequently become scared for no reason?
- 249 () Do you feel you are under considerable emotional stress?

Thank you for completing this questionnaire.

FOR MEN ONLY

- 220 () Do you have painful genitals?
- 221 () Do you have prostate troubles?
- 222 () Do you have lumps in your testicles?
- 223 () Do you have a discharge from the urethra?
- 224 () Do you have sores on external genitalia?
- 225 () Do you have difficulty getting or keeping an erection?
- 226 () Do you have difficulty completing intercourse?
- 227 () Have you had difficulty fathering children?

BEHAVIORIAL

- 228 () Do you have difficulty falling asleep?
- 229 () Do you have difficulty staying asleep?
- 230 () Do you have recurrent bad dreams?
- 231 () Do you have difficulty in concentrating?
- 232 () Is your memory poor?
- 233 () Do strange people or places make you afraid?
- 234 () Are you scared to be alone?
- 235 () Do you always need someone to advise you?