**Adult New Patient Member Questionnaire**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Form completion date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_ Time of birth\_\_\_\_\_\_\_\_ Place of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and phone no. of next-of-kin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and age of children\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Significant prior medical issues and surgeries:

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2. Significant medical issues in your family:

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1. Allergies (include reaction)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. What are your most important health goals?

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1. Self-imagination: Please draw a picture of yourself. Use a different piece of paper or the back of one of these questionnaire papers. Include where you feel pain/discomfort/tension/heaviness and where do you hold your feelings? If you have any disease or illness, please include that in the drawing. There is no wrong way to do this! It will not be graded so just have fun and draw. It doesn’t matter how many colors you use but before you begin drawing, please have access to several different colors to choose from.
2. Current medications and supplements with doses, including over-the-counter and homeopathic:

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1. Biography: Please list significant physical/emotional/spiritual life events below:

Birth and family background:

7 years old:

14 years old:

21 years old:

28 years old:

35 years old:

42 years old:

49 years old:

56 years old:

>63 years old:

1. What interests or hobbies do you have? How do you express yourself creatively?

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1. Movement: What exercise do you do? How often? Do you enjoy exercise?

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1. Do you follow/practice a spiritual/religious path? Are there meditation practices that you do? How often?

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1. What is your current and/or previous occupation? Do/did you like your job?

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1. Do you feel that you are in touch with your life’s purpose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Describe each of the following:

Sleep patterns:

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Digestion (appetite, bowel movements - diarrhea/loose/regular/constipation, gas):

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Breathing:

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Urination:

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Menses (if applicable):

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Bodily warmth/coolness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Emotional life (feelings/moods/soul life):

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Thinking/Memory (Do you have cloudy, frequent judgmental, fearful or negative thoughts etc.?):

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Food cravings/aversions:

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Eating rhythms (Are they regular etc. ?):

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Social life:

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World outlook:

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1. If your body or health had a message for you, what would it say?

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