



The Pain & Brain Healing Center

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ADULT COMPREHENSIVE BIOMEDICAL CARE QUESTIONNAIRE

Date Questionnaire Received: ____ / ____ / ____ Date of Initial Consultation: ____ / ____ / ____
[The above line is for office use only]

This adult questionnaire is to be filled out by individuals seeking biomedical for complex chronic health disorders, including but not limited to: widespread pain syndrome, fibromyalgia, chronic fatigue, depression, anxiety, early memory loss, neurological disorders, metabolic syndrome and cardiovascular issues. This clinic does not provide behavioral therapy or psychological counseling; its focus is on healing the injured nervous system.

Dear patient,

Real healing of your condition, allowing you to return to a full and vibrant life, is dependent upon revealing its actual cause(s) and pinpointing your specific metabolic needs. This is much like CSI detective work, that of gathering all the facts in your case. Once this is accomplished we can fix the problem, instead of just covering up the symptoms with drugs. To start the journey of real healing vital information about your unique health profile is needed, to assist you in providing this information a 14 page questionnaire follows. It is only as valuable in correcting your problem as the time you put into it!

PERSONAL INFORMATION:

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

Home Address: _____

Phones: (Home) _____ (Cell) _____

(Work) _____ Email: _____

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

Place of Birth: _____ Race/National/Ethnic Roots: _____

Height: _____ Weight: _____ lbs ____ Right Handed / Left Handed / Mixed Dominance

Occupation: _____

HEALTH INSURANCE INFORMATION: Please note → generally we do not take health insurance. We will provide you with a super bill to submit to your insurance for reimbursement. *

Primary Health Insurance: _____ ID/Group #: _____

Secondary Health Insurance: _____

GENERAL:

Who can we thank for referred you? _____

What brings you to our office today?

What do you hope to get from today's visit?

CURRENT HEALTH CONCERNS

PROBLEM and BRIEF DESCRIPTION	DATE OF ONSET	FREQUENCY (Daily, weekly...)	SEVERITY (mild, mood or severe)
1.			
2.			
3.			
4.			
5.			

How much time have you lost from work or school in the past year? _____

Why? _____

PRIMARY DOCTOR(S)

Name	Phone	City

Therapist(S)

Name	Type	Phone	City	Hrs/Wk

Specialists

Name	Type	Phone	City	

Chiropractor(S)/Naturopath(S)/Acupuncturist(S)

Nutritionist/Herbalists

MEDICATIONS

What are you taking **NOW** or **Recently**?

DRUG NAME- Date started drug and date stopped	DOSAGE and # per day	Good Response	No Response	Bad Response	Bad then Good

PAST MEDICAL HISTORY

Include any chronic/recurring disorder or previous problems/diseases which no longer affect you

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

PAST MEDICAL HISTORY CONTINUED

Do you have a history of Learning Problems? _____ Behavioral Issues: _____

If yes, please provide details (including how they were addressed) e.g. ADHD

Provide details of any tattoos or body piercings you may have?

Do you have amalgam (Silver) fillings in your teeth? _____

If yes, about how many do you have and for how long _____

Have you tried Chelation therapy for heavy metals such as mercury?

DMSA ___ Yes ___ No DMPS ___ Yes ___ No EDTA ___ Yes ___ No

Any benefits from chelation therapy? _____

EARLY HEALTH HISTORY

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

Do you know if you were breastfed or bottle-fed? _____

If breastfed, please indicate approximate duration: _____

Did you have any significant stresses in childhood or adolescence? _____

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 _____

Did you have a problem with bedwetting? _____

Until what age? _____

ANTIBIOTIC HISTORY

How many courses of antibiotics have you received in lifetime (approx): ___ 0 ___ 1-5 ___ 5-10

___ 10-15 ___ 15-20 ___ 20+

Main reason for antibiotic use: ___ Ear Infections ___ Bronchitis ___ Pneumonia ___ Sinus Infection

___ Intestinal Infection ___ Other (please explain) _____

Have you ever been treated for a yeast infection following antibiotic use _____

DIGESTIVE HEALTH

Do you have periodic loose stools/diarrhea ___ Yes ___ No Offensive Gas ___ Yes ___ No

Undigested Food in Stools ___ Yes ___ No Offensive Breath ___ Yes ___ No

Do you suffer with acid reflux/heartburn ___ Yes ___ No

Are you currently taking an acid-blocking medication such as Tagamet, Pepcid, etc. ___ Yes ___ No

Do your digestive problems occur more with stress ___ Yes ___ No ___ Unsure

Do you produce well formed stools ___ Yes ___ No

Have you ever produced formed stools ___ Yes ___ No

Have you taken antifungals for Candida syndrome?

Nystatin? ___ Yes ___ No Diflucan ___ Yes ___ No

Other Biomedical Therapies _____

DIETARY HISTORY

Check the most appropriate description below of my diet:

_____ Mostly carbohydrates (bread, pasta, etc.)

_____ Mostly dairy (milk, cheese, etc.)

_____ Mostly meat

_____ Mostly vegetarian (vegetables, fruits, grains, etc.)

Other. Describe: _____

Are you on a Gluten Free Diet ___ Yes ___ No

Are you on a Dairy Free Diet ___ Yes ___ No

Have you benefited by being on this diet? _____

Are you on a Low Carbohydrate Diet? _____

Are you on high Omega 3 fatty acid supplementation? ___ Yes ___ No. Any benefits? _____

FOODS I LOVE TO EAT

(Place **x** in appropriate column)

Food	Daily	3 – 5 times/ w week	1 – 3 times/ week	Never or almost never	Used to eat a Lot, but no Longer does
Cookies					
Candy					
Sweet foods					
Caffeine (soda, tea, etc.)					
Chocolate					
Milk: Whole					
2%					
1%					
Skim					
Cheese					
Ice Cream					
Salty Foods					
Meat					
Pasta					
Bread: White					
Wheat					
Other					

Please list the foods and beverages normally consumed by you for three typical days:

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 _____

For Female Patients:

FEMALE HEALTH HISTORY

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:

Do you have a history of abnormal PAP tests? _____ If yes, please describe:

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

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

Pregnancies: None _____ Term Births _____ Miscarriages _____ Abortions _____

Preemies _____ Birth weight of largest baby _____ Smallest baby _____

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

If you have never been pregnant, do you wish to have children in the future? _____

If you have children, do you plan to have more? _____

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: _____

Complications for you after delivery: _____

Did you (or do you plan to) breastfeed your children? _____

Do you take any prescription medications or natural substances for Peri or Post-menopausal symptoms? _____

If yes, provide names, dosages, etc? _____

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

Any history of yeast infections? If yes, please explain _____

MEDICAL HISTORY

Make Sure To Mark Which Tests Have Been Done And The Results

Evaluation/Test-Mark YES/NO/ Unsure If Yes Name Doctor Who Ordered Tests	Date Ordered Where Tests Performed	Results (normal, abnormal or unsure)
Physical Examination		
Eye Exam		
Dental Exam		
Breast Exam		
Digital Rectal Exam		
Stool Occult Blood		
Cholesterol Profile		
Bone Density (DEXA)		
Mammogram		
PSA		
Colonoscopy or Flexible Sigmoidoscopy		
PAP Test		
Cardiac Stress Test (Specify type)		
Hearing Test		
Amino Acid Screen-		
Blood Chemistry Screen-		
Blood Count (CBC)-		
Blood Test—Fatty Acid Profile-		
Blood Test—Food Allergies-		
CT Scan (specify area)-		
Colonoscopy-		
EEG-		
Folic Acid/Homocysteine-		

MEDICAL HISTORY

Make Sure To Mark Which Tests Have Been Done And The Results

Evaluation/Test-Mark YES/NO/ Unsure If Yes Name Doctor Who Ordered Tests	Date Ordered Where Tests Performed	Results (normal, abnormal or unsure)
Hair Elements- Toxic Metals and/or Nutritive		
Immune Profile-		
Intestinal Permeability		
Liver Detox Profile		
MRI (specify area)		
Urinary Organic Acids—fungal/bacteria		
Urinary Organic Acids—Metabolism-		
PET Scan of the Brain-		
Plasma Amino Acids		
Plasma or Serum Zinc		
RBC Elements		
Serum Ferritin (Iron stores)		
Serum Methylmalonic Acid		
Serum Vitamin A		
Small Bowel Biopsy		
Comprehensive Stool Analysis and Culture		
Stool Parasites		
Thyroid Profile		
Uric Acid (blood or urine)		
Urinary Peptides		
Urine Elements		
X-Rays (specify)		

MEDICAL HISTORY (Continued)

Major surgeries - Please describe and give dates:

SURGERY	DATE(S)	RESULTS

Major injuries - Please describe and give dates:

INJURY	DATE(S)	RESULTS

Illnesses - Please list appropriate dates and any complications:

ILLNESS	DATE(S)	COMPLICATIONS
Ear infections		
Sinus infections		
Bronchitis		
Pneumonia		
Thrush		
Chicken Pox		
Seizures		
Mono		
Others:		

SIGNS AND SYMPTOMS YOU NOW HAVE

Please check where appropriate. Leave row blank if not applicable.

DESCRIPTION	MILD	MODERATE	SEVERE	DETAILS
Fatigue				
Difficulty falling asleep				
Difficulty staying asleep				
Early waking				
Nighttime waking				
Daytime sleepiness				
Night walking				
Nightmares				
Fever				
Heat intolerance				
Cold intolerance				
Flushing				
Headache – Specify type				
Distorted feeling of self				
Auditory hallucinations				
Visual hallucinations				
Sore throats				
Distorted senses –Specify Vision/hearing/taste/smell				
Low self esteem				
Trouble remembering				
Seizures				
Anxiety				
Irritability				
Depression				
Panic Attacks				
Phobias (Specify)				
Paranoia				
Suicidal thoughts				
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				

SIGNS AND SYMPTOMS YOU NOW HAVE

Please check where appropriate. Leave row blank if not applicable.

DESCRIPTION	MILD	MODERATE	SEVERE	DETAILS
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				
Seasonal Allergies				
Palpitations				
Varicose Veins				
Angina				
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				
Abdominal pain				
Nausea				
Vomiting				
Bloating				
Belching				
Diarrhea				
Constipation				
Undigested food in stool				
Mucous in stool				
Blood in stool				

SIGNS AND SYMPTOMS YOU NOW HAVE

Please check where appropriate. Leave row blank if not applicable.

DESCRIPTION	MILD	MODERATE	SEVERE	DETAILS
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 or heels				
Cracking or peeling of hands				
Nail biting				
Soft nails				
White spots on nails				
Bedwetting				
Thickening of nails				
Fungus on nails				
Ridges on nails				
Pitting of nails				
Urinary urgency				
Urinary leaking				
Urinary pain				
Urinary hesitancy				
Kidney stones				
Blood in urine				
Prostate enlargement				
Jock itch				
Sexual problems (specify)				
Vaginal discharge				
Vaginal itching				
Postmenopausal bleeding				
Gum disease				
Dry lips				
Night blindness				
Tics				
Teeth grinding				
Tremors				
Psoriasis				
Strong body odor				

