RehabOne
RehabOne Programs | MEDICAL GROUP, INC

Dr. Elisa Yao
Holistic Clinic
Initial Visit Questionnaire

Name:____________________ Hand dominance: Right / Left Age:____ Gender:____ Height:___
Email address: ____________________________ Phone number: ________________________
How did you hear about this clinic? ____
Would you like to receive Dr. Yao's monthly holistic blog updates by email? If yes, initial here: _____
Primary Care Physician ____________________ Phone: _________________ Fax: _________________
Other doctors? ____________________________ Phone: _________________ Fax: _________________

Chief complaint (What's bothering you?): ____
How has this impacted your life? ____
____
Goals of this visit? ____
What is your attitudes regarding healthcare (check all that apply):

[ ] I want to get to the source of the problem, if possible
[ ] I only want to get rid of symptoms—give me a prescription
[ ] I am willing to make lifestyle changes if necessary
[ ] I prefer natural approaches rather than taking prescription drugs
[ ] I want to be an active participant in my healthcare and take responsibility for my health
[ ] I want to learn as much as possible about what is wrong with me

Prior work-up & results (Attach separate list if not enough space here) When done?
____ ______________
____ ______________

Prior treatment (attach separate list if not enough space here) When done? Effective? (Y/N)
____ __________ ______________
____ __________ ______________

MEDICAL HISTORY:
Major Illnesses (include childhood ones):____
Major injuries: ____
Hospitalizations: ____
Because I do injections, circle the following if you have it: Hep B; Hep C ; +HIV

ALLERGIES to medications, food or environmental agents (ie. perfumes). State reaction.
____
____

MEDICATIONS (Name, dose, frequency, when started) (Attach separate list if not enough space)
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________

SUPPLEMENTS (ie. vitamins, herbs. List what you take, dose, frequency, when started)
____
____

SURGICAL HISTORY (List year, surgeon)**:**
__________________________________ __________________________________
__________________________________ __________________________________

FAMILY HISTORY: List all serious medical conditions
Mother: ____________________ Father: ____________________ Siblings: _________________

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REVIEW OF SYSTEMS [Rank your symptoms as follows: 0=never or almost never have symptom; 1 = Occasionally have it, effect not severe; 2= Occasionally have it, effect is severe; 3=Frequently have it, effect is not severe; 4= Frequently have it, effect is severe)

GENERAL
___ Fever / Chills
___ Night sweats
___ Fatigue
___ Unexplained weight loss
___ Sweat easily

HEAD/EARS/NOSE
___ Migraine / Headache
___ Sinus problems
___ Grinding teeth
___ Eye problems: __________
___ Hearing loss / Ear Ringing

NEUROLOGY
___ Brain fog (poor concentration, poor memory)
___ Tremors
___ Nighttime leg cramps
___ Poor coordination

CARDIOVASCULAR
___ Chest pains
___ Irregular heartbeat
___ Blood clots
___ Easy bleeding/bruising
___ Swelling of feet
___ Cold hands & feet

RESPIRATORY
___ Shortness of breath with minimal exercise
___ Frequent colds / illness

GASTROINTESTINAL
___ Nausea / Vomiting / Abd pain
___ Bloating / Gas / Belching
___ Constipation
___ Diarrhea
___ Black or bloody stools
___ Heartburn
___ Excessive weight
___ Cravings for:
___ Sweets __ Salty food
___ Other: ________
___ Eating disorder

GENITOURINARY
___ Frequent urination
___ Unable to hold urine
___ Water retention
___ Kidney stones #:___
___ Wake up to urinate

PSYCHOLOGICAL
___ Sad / depressed / apathetic
___ Hyperactivity
___ Anxious, irritable
___ Obsessive thoughts
___ Panic attacks
___ Mood swings

MUSCLES/BONES
___ Muscle weakness
___ Muscle pain
___ Joint pain / Joint stiffness
___ History of multiple fractures

ENDOCRINE
___ Heat / Cold intolerance
___ Hair loss

DERMATOLOGY
___ Hives / eczema / itching
___ Acne
___ Rash

WOMEN (1st day of last period: ____)
___ Unusual periods characteristics heavy / light / irregular / clots / painful / other: _________
___ Breast soreness
___ Menopause symptoms? Y / N
___ Low sexual interest
___ Premenstrual irritability, migraines or insomnia
___ Vaginal dryness
___ Difficulty getting pregnant

MEN
___ Low sexual interest
___ Loss of drive
___ Loss of confidence
___ Loss of strength

SLEEP
___ Have trouble falling asleep
___ Have trouble staying asleep
___ **Snore /** Daytime drowsiness

Total Score: _______

LIFESTYLE HISTORY:
Smoked tobacco? Y / N # packs per day? ____ Now? ____ How many years a smoker? _____
How often do you drink alcohol a week? ___ Use illicit drugs? ___________________
History of alcohol abuse? Y / N History of drug abuse? Y / N
Marital Status: ______________ # of Children: _____ Ages of Children: _______________
Work Status: full-time / part-time) Occupation: ____________________
Highest level of education: ________________________ Hobbies: _________________________________
Exercise (type, daily or weekly amounts): ____
Circle average stress level (1 being lowest): 1 2 3 4 5 6 7 8 9 10
Identify sources of stress: (ie. work, finance, legal): ____
How do you cope with stressors? ____
Have you ever been the victim of sexual / physical / emotional abuse? Y / N / Not sure
Position of sleep: ___ on back; ___ on side (R / L); ___ on stomach

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SPIRITUAL: 0 = never, 1 = seldom, 2 = sometimes, 3 = often, 4 = regularly, 5 = daily

___ Do you share your feelings ?
___ Do you experience unconditional love?
___ Do you or did you feel close to your parents?
___ Do you feel a sense of belonging to a group?
___ Do you have ability to forgive yourself & others?

DIET

red meat – # of meals per week _______ or per day ________ ____ Eat Organic
milk – # of glasses per week ________ or per day ________ ____ Vegetarian
cheese – # of times per week ________ or per day ________ ____ Vegan
coffee or tea – # of cups per week _______ or per day ________ ____ Gluten-free
soda – # of cans per week ________ or per day ________ what kind usually? ___________
other sugar – what sweets do you usually eat and how much? ___________________________________
____
bread – what kind and how much per day or week? ____
# of non-potato vegetables per day _________ # of fruits per day _________
Which do you use (circle one)? margarine or butter What cooking oils do you use _____________
What are your favorite foods? ____

MISCELLANEOUS:

___ Lived next to highway / airport
___ Lived in old house (pre-1945)
___ Metal exposure at work
___ Coal dust or mercury exposure
___ Silver dental fillings
___ Eaten tuna fish weekly
___ Cigarette smoke exposure
___ Exposed to car exhaust or gasoline fumes
___ Eaten fish 3 or more times a week
___ Industrial chemical exposure (pesticides, paint)
___ Had root canals (#:____)
___ **# of hours sleep per night**
___ **Pregnant**? Y / N

Bowel movements – # / day ____, or # / week? ____

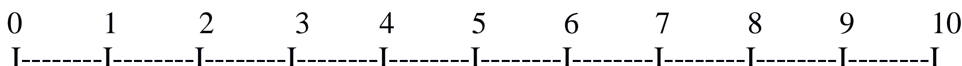
PAIN: If pain is a main concern, please complete the **pain rating** AND **pain diagram** (**next page**).

Intensity: rate your pain this past week on a 0-10 scale. (See pain scale below)

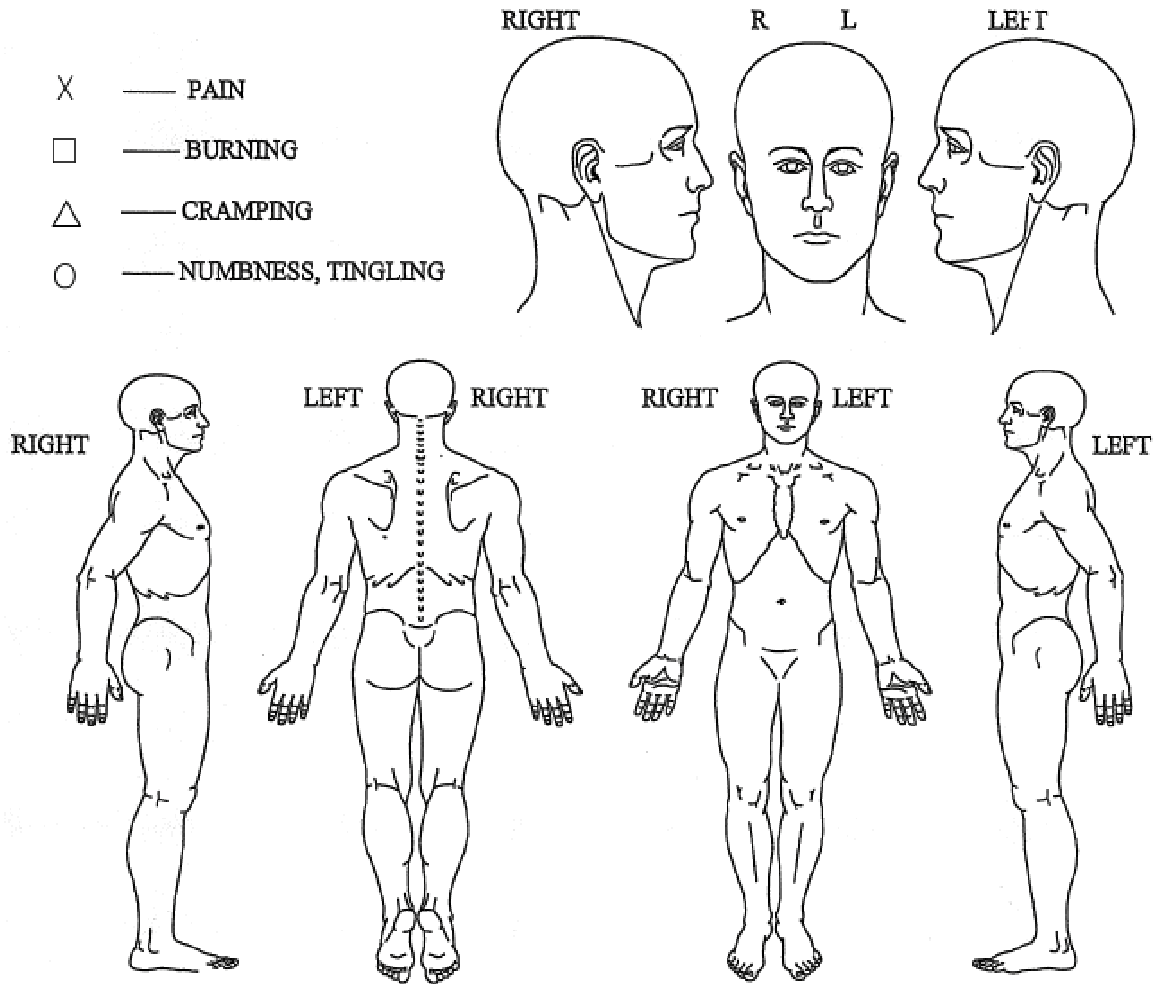
Average pain: _____ Worst pain: _____ Least pain: _____ Acceptable level of pain: _____

0 = No pain.
1 = Slightly uncomfortable. Occasional minor twinges. No medicine needed
2 = Pain is minor bother. No medicine needed.
3 = pain is annoying enough to be distracting. Mild painkillers like aspirin or tylenol help.
4 = pain can be ignored if you are really involved, but is still distracting.
5 = pain cannot be ignored for greater than 30 minutes.
6 = Pain cannot be ignored, but you can still work. Stronger narcotic painkillers help 3-4 hours.
7 = It is hard to concentrate. Pain bothers sleep. You can still function. Painkillers only help some.
8 = Your activity is limited a lot. You can talk with effort. You also experience nausea, dizziness.
9 = You cannot speak. You are crying out or moaning.
10 = You are unconscious. Pain makes you pass out.

0 1 2 3 4 5 6 7 8 9 10



Pain Diagram



Anything else you want me to know (use separate sheet if needed): ___________________________________

____

____

To the best of my knowledge, this entire questionnaire is complete and accurate.

Patient Signature: ______________________________ **Date:** ________________

Physician Signature: __________________________ **Date of Review:** _____________
(indicating form reviewed)