Stergios Tsiormpatzis
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Please take a few moments to fill out this questionnaire carefully. Your combined answers will allow us to diagnose your general health, strengths and weaknesses, in order to offer you the best possible support. All answers will be held strictly confidential. If you have any questions, please ask us. Thank you.

First & Last Name:_____ Sex: ☐ M / ☐ F

Address:_____ City: _____ Postal Code: _____

Phone: _____ Email: _____

Date of Birth / Personal Identity Number: _____ Occupation:_____

Personal and Family Medical History

Place an "X" to those that apply or give more specific details, if necessary.

	Yourself	Mother	Father	Grandparents	Brother	Sister	Children
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Bleeding Disorder							
Cancer & tumor place							
Depression							
Diabetes							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Diseases							
Headaches							
Hepatitis							
High Blood Pressure							
Kidney Disease							
Liver Disease							
Lung Disease							
Mental Illness							
Multiple Sclerosis							
Stroke							
Thyroid disorder							
Tuberculosis							

List any surgeries you've had (Include the year of the surgery and any information you consider important):

_____

_____

_____

_____

_____

_____

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Medications and Supplements

Give name, dose and amount of time you are on medication or using supplements

Medications

Med _____ Dose_____ Length of use? _____
Med _____ Dose_____ Length of use? _____
Med _____ Dose_____ Length of use? _____
Med _____ Dose_____ Length of use? _____
Med _____ Dose_____ Length of use? _____
Med _____ Dose_____ Length of use? _____
Med _____ Dose_____ Length of use? _____
Med _____ Dose_____ Length of use? _____

Supplements / Vitamins / Herbs

Name _____ Dose_____ Length of use? _____
Name _____ Dose_____ Length of use? _____
Name _____ Dose_____ Length of use? _____
Name _____ Dose_____ Length of use? _____
Name _____ Dose_____ Length of use? _____
Name _____ Dose_____ Length of use? _____
Name _____ Dose_____ Length of use? _____
Name _____ Dose_____ Length of use? _____
Name _____ Dose_____ Length of use? _____
Name _____ Dose_____ Length of use? _____

Inquiry regarding the current condition

Describe your chief complain and give a history of your present disease

Chief Complain (Include specific location of pain or discomfort, type of feeling, improvement / worsening):

_____
_____
_____
_____
_____

How and when the present condition occur: _____

_____

Physician diagnosis: _____

_____
_____
_____

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GENERAL HEALTH CONDITION INQUIRY

For the next questions, put a tick in as many boxes as appropriate. You should only tick if the condition asked about is regular. If this happened once in the last 3 months do not put a tick.

Specific Pain _____(places)

☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** ☐**7** ☐**8** ☐**9** ☐**10** (1 = Minimal pain, 10 = Extreme pain)

☐ Dull ☐ Sharp ☐ Burning ☐ Stabbing ☐ Distending ☐ _____

☐ Slow in onset ☐ Sudden in onset ☐ Contracting ☐ _____

Improved by: ☐ Pressure ☐ Heat ☐ Cold ☐ Eating ☐ Rest ☐ Movement

☐ Lying down ☐ Sitting ☐ Climate / Moisture ☐ _____

Worsen by: ☐ Pressure ☐ Heat ☐ Cold ☐ Eating ☐ Rest ☐ Movement

☐ Lying down ☐ Sitting ☐ Climate / Moisture ☐ _____

General Pain and Body Condition

☐ Pain all over with a sensation of tiredness ☐ Pain in all muscles with a hot sensation on the skin

☐ Headaches ☐ Migraines ☐ Body aches ☐ Neck pain ☐ Shoulders pain ☐ Knee pain

☐ Chest pain ☐ Chest pain with coughing and yellow sputum ☐ Genera muscles pains ☐ Weak limbs

☐ Numbness ☐ Heaviness ☐ Stiffness ☐ Spasms ☐ Shaking in muscles ☐ Swollen ankles

☐ Distension and stiffness at the bottom of the rib cage ☐ Sores in mouth ☐ Palpitations

☐ Sore throats and low grade fever ☐ Nasal congestion ☐ Coughing

Joint pain that is: ☐ moving from joint to joint ☐ Fixed and strong ☐ With numbness and swelling

Back pain that is: ☐ continuous and dull ☐ Worse during cold periods ☐ Low back pain

Pain in the stomach that is: ☐ Severe ☐ Dull ☐ Better by eating ☐ Worse by eating

Pain in your lower abdomen that is: ☐ Better by bowel movement ☐ Worse by bowel movement

_____

_____

_____

_____

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Cold and Heat

☐ Prefer cold ☐ Prefer heat ☐ Cold hands / feet ☐ Hot hands / feet ☐ Cold back

☐ Chills ☐ Low grade fever come and go ☐ Fever ☐ _____

Sweating

The following questions are about **unusual** sweating on the body. Tick only if the condition happens in the absence of heavy exercise (in which case you would be expected to sweat.)

☐ Spontaneous ☐ With mild exercise ☐ No sweating even with exercise ☐ Hot flashes

☐ Daytime ☐ Afternoon ☐ Night sweats ☐ Salty ☐ Oily ☐ With smell

Local sweats on:

☐ Forehead ☐ Head ☐ Palms, soles and chest ☐ Hands only ☐ Legs and arms only

☐ _____

Energy ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (1 = Minimal energy, 10 = Maximal energy)

☐ Excess ☐ Fatigue ☐ Fatigues easily ☐ Sudden energy drop ☐ Little desire to speak

☐ Little desire to move ☐ Feel sleepy ☐ Dyspnea ☐ Fainting ☐ Shortness of breath ☐ Heavy feeling

☐ _____

Memory and Sleep _____ Hrs/night.

Sound sleep is an important health factor. Complete this section to let us know of any particular sleeping problems you may have. You should only tick if the condition asked about is regular i.e. tick Difficulty in falling asleep only if this happens more often than not.

☐ Strong memory ☐ Weak short-term memory ☐ Weak long-term memory

What time you usually go to sleep _____ How long it take you to sleep _____

☐ Waking earlier than you would like and are unable to return to sleep.

If yes, what time: ☐ 23-01 ☐ 01-03 ☐ 03-05 ☐ 05-07 ☐ 07-09

☐ Sound, restful ☐ Waking up in the night ☐ Feel sleepy after eating ☐ Insomnia

☐ Heavy sleep ☐ Dream disturbed ☐ Not restful ☐ Grinds teeth ☐ _____

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Headaches and dizziness

☐ Recent onset headache (last 10 days) ☐ Come on slowly ☐ Daytime only ☐ Evening only

Located principally in: ☐ Neck ☐ Forehead ☐ Temples and side of head ☐ Top of head

☐ All of head ☐ _____

☐ Heavy feeling ☐ Distended and throbbing ☐ Like a nail on a small point ☐ Worse by heat

☐ Worse by cold ☐ Worse by tiredness, improved by rest ☐ Migraines ☐ Severe dizziness

☐ Slight dizziness with a sensation of muzziness ☐ Slight dizziness which is worse when tired

Urine

☐ Normal ☐ Polyuria ☐ Oliguria ☐ Urgency ☐ Incontinence (inability to control bladder)

☐ Nocturia (wake up at night in order to urinate) ☐ Infrequent ☐ Cystitis (inflammation of the bladder)

☐ Prostatic Hyperplasia ☐ Hematuria ☐ Clear ☐ Cloudy ☐ Dark ☐ Excess

☐ Scanty ☐ Frequent ☐ Strong smell ☐ Low pressure ☐ Difficult starting

☐ Retention (inability to empty bladder)

Dysuria with: ☐ Pain before urination ☐ Pain during urination ☐ Pain after urination

☐ _____

Stool

☐ Regular ☐ Loose / watery ☐ Foul smell ☐ Dry / Hard ☐ Burning ☐ Undigested food

☐ Gas ☐ Hemorrhoids ☐ With red blood ☐ With dark blood ☐ _____

Diarrhea that is: ☐ Painful ☐ Chronic ☐ Every morning ☐ Alternated with constipation

Constipation that is: ☐ Acute ☐ With small bitty stools ☐ With abdominal pains

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Thirst - Drinks

Thirsty with: ☐ desire to drink ☐ no desire to drink ☐ desire to sip liquids slowly

☐ No thirst ☐ Heavy thirst ☐ Likes cold drinks ☐ Likes hot drinks ☐ Dry mouth ☐ Dry lips

☐ Bitter taste in mouth ☐ Metal taste in mouth ☐ _____

Appetite ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 (0 = No appetite, 5 = Heavy appetite)

☐ Cravings ☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Gas ☐ Bloating ☐ Heartburn

☐ Loss of appetite ☐ Poor appetite ☐ Digestive problems ☐ Food allergies ☐ Bad Breath

Preferred tastes: ☐ Sweet ☐ Bitter ☐ Sour ☐ Salty ☐ Pungent

Not - preferred tastes: ☐ Sweet ☐ Bitter ☐ Sour ☐ Salty ☐ Pungent

Emotions

☐ Calm / relaxed ☐ Depressive ☐ Anxious ☐ Angry ☐ Irritable ☐ Stressed

☐ Grief ☐ Overthinking ☐ Fearful ☐ _____

Lifestyle and Body Type

☐ Smoking ☐ Easy weight gain ☐ Easy weight loss ☐ Thin body ☐ Heavy body ☐ Irregular hours

☐ Shift work ☐ Regular Exercise ☐ Alcohol ☐ Caffeine ☐ Tension

☐ Occupational stress factors: _____

Eyes

☐ Blurry vision ☐ Spots in front of eyes ☐ Poor vision ☐ Eye pain ☐ Eyestrain ☐ Dry eyes

☐ Burning ☐ Sand sense ☐ Pressure ☐ Swelling ☐ Crossed eyes ☐ Double vision

☐ Red eyes ☐ Yellow eyes ☐ _____

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Ears

☐ Poor Hearing ☐ Sudden onset of deafness ☐ Slow onset of deafness ☐ Earaches

☐ Tinnitus (Ringing in ears) ☐ High pitch noise, like a whistling ☐ Low sound noise, like rushing water

☐ Noise made worse by pressing on the ear ☐ Noise made better by pressing on the ear

☐ _____

Skin and Hair

☐ Rashes ☐ Itching ☐ Dry skin ☐ Ulcerations ☐ Eczema ☐ Urticaria ☐ Dandruff

☐ Hair loss ☐ Changes in skin / hair ☐ Dry hair ☐ Psoriasis ☐ _____

Gynecology - Menstruation

☐ Regular ☐ Irregular ☐ Amenorrhea ☐ Heavy flow ☐ Light flow ☐ Pale color

☐ Dark color ☐ Clots ☐ PMS ☐ Vaginal discharge: _____

☐ Breasts distension ☐ Lumps in the breasts

Pain: ☐ before period ☐ during period ☐ after period ☐ no pain

Age at first period: _____ Age at menopause: _____ Number of Pregnancies: _____
Time between cycles: _____ Duration of bleeding: _____ First day of last period: _____
Hormonal contraceptive (name & type): _____ For how long: _____

☐ _____

Other Health Concerns

_____

_____

_____

_____

_____

_____

_____