New Patient Acquaintance Comprehensive Questionnaire - Male

How to complete this questionnaire: Mail to:
Fenton Functional Nutrition, LLC
PO Box 9281
Calabasas, CA 91372
Or email to: FentonFunctionalNutrition@gmail.com
Thank you & I look forward to helping you regain full health

Today's Date:	Name:	Age	DOB	Male
Address:				
Mobile:	Home:	Email:		
Relationship Status:		Name & Contact Number for Spouse/Partner:		
Children & their ages:		Occupation:		
Emergency contact person & number:		Height:	Current Weight:	Happiest Weight:

Provide details of any medical or allied health professionals you see on a regular basis:

Name & Profession (e.g. MD, acupuncturist, etc.)	Address & Contact Number	Reason for visiting

How did you find out about me? Please let me know the person who referred you so I may thank them

What is your reason for visiting with us?
Please detail your current health concern - please think about the following and give as much detail as possible:

- Date of onset – when did it start?
- Frequency: daily, monthly, yearly?
- How long does it last (minutes, hours, weeks etc) or is it chronic?
- Severity of the symptoms: rate from 1 (lowest) to 10 (highest)
- Describe the symptoms in as much detail as possible and the area of your body affected
- What (if anything) triggers the onset and exacerbates the symptoms?
- Have you sought medical treatment for this health issue? If so, what medication was prescribed, advice given? Has that provided any relief?
- What (if anything) helps alleviate the symptoms or resolves them completely?
- Is there any time of day/year that makes it worse? Or better?

Is there another MAIN health concern? If yes, provide details as above

From your first visit with us **what is the ONE MAIN thing you wish to achieve to feel better?** i.e. what is having the most impact on your life? (Physical, mental, emotional) & how committed are you to making that happen?

What is your main expectation of us?

Major Illness & Surgery - Please list any instances where you suffered from a major illness, were admitted to hospital or underwent surgery from infancy to present time

Age	Treatment/Surgery & Reason	Length of Stay

Detail all CURRENT medications (prescribed/over the counter)

Brand & Product name	Dose+Frequency	Reason for taking	Date Started

Detail all PAST medications in last 5 years

Brand & Product name	Dose+Frequency	Reason for taking	Date Started

Detail all CURRENT supplements (e.g. vitamins/herbal medicines)

Brand & Product name	Dose+Frequency	Reason for taking	Date Started

What are your current lifestyle and health habits & challenges?	
E.g. don't get enough sleep, no time to prepare healthy meals, drink too much alcohol on weekends etc These are areas where you already know you may be compromising your health, or an issue that you know needs to change but you may not know how	
Food – do you regularly cook/eat healthy nourishing meals?	
Sleep – how would you rate your sleep quality – 1 lowest & 10 highest quality? Do you wake up refreshed?	
Rate your average energy levels: 1 lowest to 10 highest	
Stress: would you consider yourself stressed and if Y, what are the contributing factors? Work, Home, Family?	
Self care, hobbies and relaxation? What do you do for these and how many times per week?	
Occupational health & safety risks? e.g. radiation from frequent flying, chemicals at work etc	
Addictions e.g. smoking, drugs, coffee/tea, alcohol Please make note of past history for any of these substances	
Anything else you believe may be holding you back?	
Allergies - Do you suffer from any allergies, sensitivities or intolerances? For example: prescribed/over the counter medications, foods, animals/insects, chemicals (food additives, cleaning/gardening chemicals), plants/grass/pollen, air pollution/petrol fumes/dust, skin reactions to plasters/lotions/fabrics/toiletries etc. What are the details & reactions?	

Please read the questions and highlight the appropriate boxes

Diet - Do you consume any of the following?

☐ Alcohol	☐ Caffeinated Drinks	☐ Margarine
☐ Artificial sweeteners	☐ Fast foods	☐ Milk products
☐ Sweets, deserts, refined sugars	☐ Fried Foods	☐ Diet frequently for weight control
☐ Carbonated drinks	☐ Luncheon meats	☐ Cigarettes
☐ Chewing gum	☐ Processed meats e.g. salami, pastrami	

Lifestyle

How many times per week do you exercise, what types of exercise & the duration?

Have you had any of the following events occur within the past 2 years?

☐ Changed Jobs ☐ Separated or Divorced ☐ Worked over 50 hours per week ☐ Moved house ☐ Grief/ lost loved one

Name: **DOB:**

Group 1

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Belching or gas within one hour of eating	☐	☐	☐	☐	Feel like skipping breakfast
☐	☐	☐	☐	Heartburn or acid reflux	☐	☐	☐	☐	Feel better if you do not eat
☐	☐	☐	☐	Stomach bloating within one hour after eating	☐	☐	☐	☐	Sleepy after meals
☐	☐	☐	☐	Vegan Diet	☐	☐	☐	☐	Fingernails chip peel or break easily
☐	☐	☐	☐	Bad Breath/Halitosis	☐	☐	☐	☐	Anemia that is unresponsive to iron supplements
☐	☐	☐	☐	Stomach pains or cramps	☐	☐	☐	☐	Loss of taste for meat
☐	☐	☐	☐	Diarrhea, chronic	☐	☐	☐	☐	Diarrhea shortly after meals
☐	☐	☐	☐	Sweat often has a strong odor	☐	☐	☐	☐	Stomach upset by taking vitamins
☐	☐	☐	☐	Black or tarry colored stools	☐	☐	☐	☐	Sense of fullness after meals
☐	☐	☐	☐	Undigested food in stools					

Group 2

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Food Allergies	☐	☐	☐	☐	Wheat or grain sensitivity
☐	☐	☐	☐	Abdominal bloating 1 to 2 hours after eating	☐	☐	☐	☐	Dairy sensitivity
☐	☐	☐	☐	Pulse speeds after eating	☐	☐	☐	☐	Asthma, sinus infections, stuffy nose
☐	☐	☐	☐	Airborne allergies	☐	☐	☐	☐	Bizarre vivid dreams, nightmares
☐	☐	☐	☐	Experience hives	☐	☐	☐	☐	Use over-the-counter pain medication
☐	☐	☐	☐	Sinus congestion “stuffy head”	☐	☐	☐	☐	Feel spacey or unreal
☐	☐	☐	☐	Crave bread or noodles	☐	☐	☐	☐	Specific foods make you tired or bloated
☐	☐	☐	☐	Alternating constipation and diarrhea				☐	Are there any foods you could not give up (☒ = yes)
								☐	Have a history of or currently have Crohn’s disease (☒ = yes)

Group 3

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Anus itches	☐	☐	☐	☐	Irritable bowel or mucus colitis
☐	☐	☐	☐	Coating on the tongue	☐	☐	☐	☐	Blood in stool
☐	☐	☐	☐	Feel worse in mouldy or musty places	☐	☐	☐	☐	Mucus in stool
☐	☐	☐	☐	Fungus or yeast infections	☐	☐	☐	☐	Excessive foul smelling lower bowel gas
☐	☐	☐	☐	Ring worm, “jock itch”, “athletes foot”, nail fungus	☐	☐	☐	☐	Bad breath or strong body odours

Group 3 continued

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Symptoms above increase with sugar/starch/alcohol	☐	☐	☐	☐	Cramping in lower abdominal region
☐	☐	☐	☐	Stools hard or difficult to pass	☐	☐	☐	☐	Lower abdominal pain, cramping and/or spasms
☐	☐	☐	☐	Less than one bowel movement per day	☐	☐	☐	☐	Raw fruits/vegetables/stress aggravate bowel pain
☐	☐	☐	☐	Lower abdominal pain, relief by passing stool or gas	☐	☐	☐	☐	More than three bowel movements daily
☐	☐	☐	☐	Diarrhea (Loose watery stool)	☐	☐	☐	☐	Hard dry or pellet stool
☐	☐	☐	☐	Extremely narrow/ribbon like stool	☐	☐	☐	☐	Alternating Diarrhea/constipation
☐	☐	☐	☐	Feel bowels do not completely empty	☐	☐	☐	☐	History of parasites
☐	☐	☐	☐	Stools are not well formed (loose)					

Group 4

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Aware of heavy and/or irregular breathing	☐	☐	☐	☐	Ankles swell especially at end of day
☐	☐	☐	☐	Cough at night	☐	☐	☐	☐	Air hunger or sigh frequently
☐	☐	☐	☐	Blush or face turns red for no reason	☐	☐	☐	☐	Compelled to open windows in a closed room
☐	☐	☐	☐	Dull pain or tightness in chest and/or radiate into right arm, worse with exertion	☐	☐	☐	☐	Shortness of breath with moderate exertion
☐	☐	☐	☐	Muscle cramps with exertion					

Group 5

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Pain in mid back region	☐	☐	☐	☐	Cloudy, bloody or darkened urine
☐	☐	☐	☐	Puffy around the eyes, dark circles under the eyes	☐	☐	☐	☐	Urine has a strong odor
☐	☐	☐	☐	History of Kidney stones					

Group 6

Never	**In the Past**	**Occasionally**	**Frequently**		**Never**	**In the past**	**Occasionally**	**Frequently**	
☐	☐	☐	☐	Stomach upset by greasy foods	☐	☐	☐	☐	Sensitive to chemicals (perfume, cleaning agents)
☐	☐	☐	☐	Nausea	☐	☐	☐	☐	Sensitive to tobacco smoke
☐	☐	☐	☐	Light or clay coloured stools	☐	☐	☐	☐	Exposure to diesel fumes
☐	☐	☐	☐	Headache over eyes	☐	☐	☐	☐	Pain under right side of rib cage

Group 6 continued

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Consume artificial sweeteners (e.g. aspartame)	☐	☐	☐	☐	Hemorrhoids or varicose veins
☐	☐	☐	☐	Gallbladder removed (highlight box)	☐	☐	☐	☐	Sensitive to artificial sweeteners (e.g. aspartame)
☐	☐	☐	☐	Do you feel sick if you drink wine	☐	☐	☐	☐	Chronic fatigue or fibromyalgia
☐	☐	☐	☐	Easily intoxicated if you drink wine	☐	☐	☐	☐	Stool color alternates from clay color to brown
☐	☐	☐	☐	History of morning sickness	☐	☐	☐	☐	Easily hung over if you were to drink wine
☐	☐	☐	☐	Dry, flaky skin, hair	☐	☐	☐	☐	Bitter taste in mouth especially after meals
								☐	Yellowish colour of skin or eyes

Group 7

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Bone loss (reduced density on bone scan)	☐	☐	☐	☐	Morning stiffness
☐	☐	☐	☐	Calf, foot or toe cramps on rest	☐	☐	☐	☐	Crave chocolate
☐	☐	☐	☐	Cold sores, fever blisters or herpes lesions	☐	☐	☐	☐	History of anemia
☐	☐	☐	☐	Frequent skin rashes and/or hives	☐	☐	☐	☐	White spots on fingernails
☐	☐	☐	☐	Excessively flexible joints (double jointed)	☐	☐	☐	☐	Cuts heal slowly and/or scar easily
☐	☐	☐	☐	Joints pop or click				☐	Herniated disc (☒ = yes)
☐	☐	☐	☐	Decreased sense of taste or smell				☐	History of bone spurs (☒ = yes)

Group 8

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Muscles become easily fatigued	☐	☐	☐	☐	Whole body or limb can jerk as falling asleep
☐	☐	☐	☐	Feel exhausted or sore after moderate exercise	☐	☐	☐	☐	Night sweats
☐	☐	☐	☐	Vulnerable to insect bites	☐	☐	☐	☐	Restless leg syndrome
☐	☐	☐	☐	Numbness, tingling or itching in hands and feet	☐	☐	☐	☐	Cracks at corner of mouth
☐	☐	☐	☐	Depressed	☐	☐	☐	☐	Fragile skin, easily chaffed, as in shaving
☐	☐	☐	☐	Worrier, apprehensive, anxious	☐	☐	☐	☐	Small bumps on back of arms
☐	☐	☐	☐	Nervous or agitated	☐	☐	☐	☐	Nose bleeds and/or tend to bruise easily
☐	☐	☐	☐	Feelings of insecurity	☐	☐	☐	☐	Bleeding gums especially when brushing teeth

Group 9

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Difficulty gaining weight even with large appetite	☐	☐	☐	☐	Swollen upper eyelids
☐	☐	☐	☐	Nervous, emotional, can't work under pressure	☐	☐	☐	☐	Muscles weak, cramp or tremble
☐	☐	☐	☐	Inward trembling	☐	☐	☐	☐	Slow mental processes, forgetfulness
☐	☐	☐	☐	Flush easily (go red)	☐	☐	☐	☐	Slow heart beats
☐	☐	☐	☐	Fast pulse at rest	☐	☐	☐	☐	Loss of appetite
☐	☐	☐	☐	Intolerance to high temperatures	☐	☐	☐	☐	Abdominal swelling
☐	☐	☐	☐	Fatigued, sluggish	☐	☐	☐	☐	Unsteady gait, movements
☐	☐	☐	☐	Feel cold – hands, feet	☐	☐	☐	☐	Lack of interest in sex
☐	☐	☐	☐	Outer third of eyebrow thinning/thinning hair – scalp/face/genitals	☐	☐	☐	☐	Gain weight easily (highlight box)
☐	☐	☐	☐	Puffy face, hands, feet	☐	☐	☐	☐	Swelling of the neck (highlight box)

Group 10

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Runny or drippy nose	☐	☐	☐	☐	Acne (Adult)
☐	☐	☐	☐	Catch colds at the beginning of winter	☐	☐	☐	☐	Itchy skin (dermatitis)
☐	☐	☐	☐	Mucus producing cough	☐	☐	☐	☐	Cysts Boils Rashes
☐	☐	☐	☐	Never get sick					

Do you have any history of Epstein Barr, Glandular Fever, Herpes, Shingles, Chronic Fatigue Syndrome or other chronic viral conditions?

1 / year	2 to 3 / year	4 to 5 / year	6 plus / year	
☐	☐	☐	☐	Frequent colds or flu
☐	☐	☐	☐	Other infections (Sinus, ear, lung, skin, bladder, etc)

Name: **DOB:**

Group 11

Never	In the Past	Some times	Frequently		Never	In the past	Some times	Frequently	
☐	☐	☐	☐	Awaken a few hours after falling asleep, hard to get back to sleep	☐	☐	☐	☐	Headaches if meals are skipped or delayed
☐	☐	☐	☐	Crave sweets at any time	☐	☐	☐	☐	Irritable before meals
☐	☐	☐	☐	Binge or uncontrolled eating	☐	☐	☐	☐	Shaky if meals delayed
☐	☐	☐	☐	Excessive appetite	☐	☐	☐	☐	Frequent thirst
☐	☐	☐	☐	Crave coffee or sugar in the afternoon	☐	☐	☐	☐	Frequent urination
☐	☐	☐	☐	Sleepy in the afternoon					Number of family members with diabetes, please list:
☐	☐	☐	☐	Fatigue that is relieved by eating					

Group 12

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
☐	☐	☐	☐	Tend to be a “night person”	☐	☐	☐	☐	Chronic low back pain, worse with fatigue
☐	☐	☐	☐	Difficulty falling asleep	☐	☐	☐	☐	Become dizzy when standing up too suddenly
☐	☐	☐	☐	Slow starter in the morning	☐	☐	☐	☐	Crave salty foods
☐	☐	☐	☐	Tend to be keyed up, trouble calming down	☐	☐	☐	☐	Salt foods before tasting
☐	☐	☐	☐	Blood pressure above 120/80	☐	☐	☐	☐	Perspire easily
☐	☐	☐	☐	Headache after exercising	☐	☐	☐	☐	Chronic fatigue or get drowsy easily
☐	☐	☐	☐	Feeling wired or jittery after drinking coffee	☐	☐	☐	☐	Afternoon yawning
☐	☐	☐	☐	Clench or grind teeth	☐	☐	☐	☐	Afternoon headache
☐	☐	☐	☐	Calm on the outside, troubled on the inside					

Family Health: Please list any known family medical history & indicate if deceased due to health issue: e.g. strokes, heart disease, high blood pressure, digestive disorders – Celiac, thyroid disorders – Hashimoto's, mental illness/depression/anxiety etc

Mother	Father
Grand Parents (Maternal)	Grand Parents (Paternal)
Siblings (Sisters)	Siblings (Brothers)

Your Gestational History - did your mother suffer from any of the following while she was carrying you? Gestational diabetes, threatened miscarriage, high/low blood pressure, serious infections. If Y, provide details.

Your Birth History – provide details if possible i.e. born prematurely, birth induced, birth trauma/injury, normal vaginal birth, caesarean section, prolonged labour/delivery, oxygen deprivation, forceps/vacuum

Childhood History: from birth to 18 years did you suffer from any of the following illnesses?
ADD, ADHD, Allergies, asthma, bronchitis, chickenpox, colic, croup, eczema, measles, mumps, newborn jaundice, psoriasis, rubella, scarlet fever, tonsillitis, whooping cough
Please insert the condition as appropriate. Severity out of 10 where 1 = mild & 10 = very severe

Health Condition	Age at onset	Age it resolved	Severity	Treatment Received
			/10	
			/10	
			/10	

Immunizations - Please list all vaccinations you have had that you can remember & are you aware of any side effects or adverse reactions to any immunizations you have received?

Environmental Toxicity Screening	Answer Y/N. If Y, provide detail
In the past two years, have any of your activities involved frequent contact with chemicals including: manufacture or degrading of plastics; paints; new carpets; new car; refrigeration or air conditioning gases; glues; chemical cleansers or insecticides (pest control) or herbicides; frequent handling of carbonless copy paper; retail shop receipts; unfiltered water; chemical mold removal; hair chemicals such as coloring or perming agents? If yes, give details and dates:	
In the past two years have any of your activities involved contact with heavy metals? If yes, give details and dates:	
Have you had any X-rays (including dental) in the past three years? If yes, give details and dates: When was your last dental check up?	
What is the number of international & domestic flights taken in past 3 years? (radiation exposure)	
Do you use a computer? If yes, for how many hours per day? (laptop/desktop/flat screen) Do you use a laptop/tablet on your lap?	
Do hold your mobile phone to your head when using it? If Y, how many hours/day?	
Do you sleep near your mobile phone or ipad? Do you use it as an alarm? Do you have electrical devices in the bedroom e.g. TV? Do you sleep near a fuse box? What is on the other side of your bedroom wall where your head is located?	
Do you use a microwave oven? If yes, how often?	
Do you live/work near a transmitter/power lines?	
Do you live/work near a main road/flight path?	
Do you regularly travel in rush hour/busy traffic? If so how? Bike, bus, car, walk?	
Do you use chemical cleansers or insecticides in your kitchen or bathroom? If yes, give details	
Have you recently conducted any renovations/decorating and/or pest control? If yes, give details:	
Do you use any recreational drugs including alcohol? If yes, give details including type, amount and frequency & duration	
Do you smoke cigarettes? If yes, what strength and how many per day/week? Duration (number of years)?	
Have you stopped smoking cigarettes in the past four months? If yes, when?	
Are you exposed to passive smoking? If yes, how often?	
Do you drink coffee, caffeine containing drinks or tea? If yes, give details including what, how often and how much:	
Do you wash your fruit and vegetables really thoroughly before eating them?	
Do you have any mold in your home/work environment? Details?	

Please complete the entire Questionnaire. Do complete by hand and return via mail 5 days prior to your Initial Consultation –

Mail to:

Fenton Functional Nutrition, LLC
PO Box 9281
Calabasas, CA 91372

Or email to: FentonFunctionalNutrition@gmail.com

Bring along to your first appointment:

1. Current medications – both prescription, herbal/nutritional supplements
2. Recent test results (within 12 months only): such as blood work, fecal test, saliva test, hair mineral analysis, ultrasounds and any other medical records or doctor reports.

Signature:	Date:
Signature of Parent/Guardian for children under 18 years	