FIRST VISIT QUESTIONNAIRE

Personal Information

Name ______________________________

Street Address ______________________________

City, State, Zip ______________________________

Telephone: Day ______________ Night ______________

Age ________ Date of birth ____________ Birthplace ____________

Marital Status____________ Number and ages of children ____________

Accompanied by ______________________________

Relationship to you ______________________________

How were you referred ______________________________

Occupation ______________________________

Previous occupation if retired ______________________________

Days, weeks, months or years of macrobiotic practice? ______________

What was your previous diet? ______________________________

Approximate body weight ______________Height ______________

How is your bowel movement? ______________________________

How many times a day do you urinate? ______________________________

Color of urine: _____Transparent _____ Dark yellow _____Light Yellow

Cooking & Diet

Do you cook with: ___Gas ___Electricity ___Microwave

Please check the foods you have been eating regularly, a few times a week.

___Whole cereal grains

___Fresh vegetables, cooked

___Fresh vegetables, raw

___Beans

___Seaweed

___Fruit

___Fish

___Nuts

___Seeds

___Vegetable oil

___Meat

___Poultry

___Eggs

___Dairy Food

___Refined Flour Products

___Canned Food

___Frozen Foods

___Sugar, honey, chocolate, carob

___Artificial sweeteners, soft drinks

___Spices, herbal teas

Present Symptoms (Please list)

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Previous Illnesses, Accidents & Surgeries

Have you had any psychological problems? If yes, please specify the type and treatment you have had. ____________________

____

Have you had any previous major illnesses, miscarriages, accidents, broken bones or other surgeries including tonsils, appendix or abortions? If yes, please specify and give dates.

Date	Type of Problem

Present Concerns

What is the reason for your visit? Please specify such as: general dietary or lifestyle guidance; a specific health problem or illness; or a psychological problem? ____________________

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____

If you have a particular disorder, when was it diagnosed? ____________________

____

Are you presently under the care of a doctor or other health professional? If yes, please specify.

____

Are you currently receiving any medical treatments? If yes, please specify: ____________________

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____

Have you had any surgery and/or medical treatments such as radiation or chemotherapy for your present problem? If yes, please specify. ____________________

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____

Are you currently taking any medications, vitamins or supplements? If yes, please list below.

____

____

For Women:

Are your menstrual cycles regular? ____________________

How many days in between periods? ____________________

How many days does it last? ____________________

Do you feel pain or discomfort? If so,when: _____Before ___During

Do you have vaginal discharge? ____________________

What type of birth control do you use? ____________________

If you have children, did you have normal childbirth? ____________________

Any Other Comments: Please write down typical meals + Times:

BreakFast:

Lunch:

Dinner: