Dr. Laura Futterman
Naturopathic Physician
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Stamford, CT 06905
(203) 325-3535

ALL INFORMATION YOU PROVIDE IN THIS QUESTIONNAIRE
WILL BE KEPT STRICTLY CONFIDENTIAL

Name of patient: Date of Birth

Address Male/Female

City, State, Zip Code

Daytime Phone Cell Phone

Evening Phone Occupation

Social Security #

If patient is a *child*, name of *mother*:

Married/Single/Divorced/Committed Relationship/Separated/Widowed/Widower

# of chidren; ages of children

Name of *insured* person, if different from patient:

Social Security # of *Insured* Person:

Date of Birth of *Insured* Person:

Address, phone # of *insured*, if different from patient

What is the health concern which is of greatest importance to you?_____

_____

Please list other health issues, even if you don't know if they are related to your main problems

1_____ 2_____ 3_____

4_____ 5_____ 6_____

Are you currently under the care of another doctor for these conditions? *Yes/No/Kind of*

Do you have any *known* allergies to foods or medications:_____

_____

Please list any prescription medicine you currently take:_____

_____

Please list any over the counter medicine you take regularly:_____

_____

Please list any nutritional, herbal, or other supplements you take regularly:_____

_____

Have you ever been hospitalized for a psychiatric illness, or attempted suicide? *Yes/No*

Basic Details of above _____

Please list any hospitalizations you've had, and their dates:_____

_____

Have you ever had a root canal? *Yes/No?* When?

Have you had your tonsils removed? *Yes/No* When?

Have you ever had frequent ear infections, tonsillitis, sore throats, or other problems that required repeated antibiotic prescriptions? *Yes/No/Not Sure*

How many times have you been on antibiotics within the past two years?

Have you ever been on a diet/natural health program that made you feel great? *Yes/No/Maybe*

Basic Details of Above_____

Has there been an illness or event in your life from which you feel you never fully recovered?

Yes/No/It's complicated Basic Details_____

Do you feel irritable, shaky, or faint if you don't eat on time? *Yes/No/Sometimes/Not Sure*

Do you crave carbohydrates? (sugar, rice, bread, potatoes, etc) *Yes/No/Sometimes/Not Sure*

Have you ever been exposed to chemical toxins, pesticides, herbicides, heavy metals, prolonged exposure to construction materials (carpeting, cabinetry, etc.) *Yes/No/Not Sure*

Does coffee keep you up at night if you drink it in the afternoon or evening? *Yes/No/Not Sure*

Do medications have bad or unexpected effects on you? *Yes/No/Maybe/Sometimes/Not Sure*

Details of above_____

Do you have a history of substance abuse or addiction? (Alcohol, drugs, medications)

Basic Details of above_____

How much stress do you feel in your life? 1=low, 10 =very high 1 2 3 4 5 6 7 8 9 10

When you wake up in the morning, do you feel: *Great/Good/Tired/Groggy/Depressed/Irritable*

How did you hear about Dr. Futterman? Is there someone we can thank for referring you?