CBD Training Academy

Patient Questionnaire

Personal Information

First name, Last name_____

Date of birth:_____

Preferred Name_____

Age _____

Gender:

Male _____

Female _____

Genetic Background

African American * Native American * Mediterranean * Hispanic * Caucasian * Northern European * Asian * Other

If other, please specify

Primary Address

Street Unit:_____

City State/Province Postal code _____

Preferred Primary Phone Please specify if Home, Cell or Work number:_____

Secondary Phone Please specify if Home, Cell or Work number:_____

Email Address:_____

Best way to contact? (Circle one please)

Email * Phone * Text/Other: (please provide # or specify method):_____

Ok to leave a message? (Circle one): Yes * No

Primary Physician

Title First name Last name:_____

Street Unit :_____

City State/Province Postal code :_____

Work phone Mobile phone Fax number:_____

Email address:_____

Title/Occupation:_____

Other Pertinent Provider

Title First name Last name:_____

Work phone Mobile phone Fax number:_____

Email address:_____

Title/Occupation:_____

City:_____

Other Pertinent Provider

Title First name Last name:_____

Work phone Mobile phone Fax number:_____

Email address:_____

Title/Occupation:_____

City:_____

Referred by:_____

Goals & Concerns

What do you hope to achieve in your visit?:_____

List your three main health/nutrition concerns:

Health/Nutrition Concerns

1.
2.
3.

When was the last time you felt well?:_____

Did something trigger your change in health?:_____

What makes you feel better?:_____

What makes you feel worse?_____

Comments:_____

Allergy Information

Please list food allergies:_____

Please list non-food allergies including medications/supplements:(use space below)

Please list environmental allergies:_____

What type of allergic symptoms do you experience?:_____

Family History Please note any family history of the following diseases: heart disease, cancer, stroke, high blood pressure, overweight, lung disease, kidney disease, diabetes, mental illness or addiction, etc.

Family History:_____

Family Member:	Health Condition:

Known Genetic Disorders:_____

Comments:_____

Medical History Please check health conditions that your doctor has diagnosed and provide the method of treatment recommended and followed

Gastrointestinal

- **Please mark C or P: Currently (C) or In the past (P)?**

Celiac Disease

Crohn's Disease

Gastric or Peptic Ulcer Disease

GERD/heartburn/reflux

Irritable Bowel Syndrome

Liver Disease

Small Intestinal Bacterial Overgrowth

Ulcerative Colitis

Other Gastrointestinal conditions: Indicate if Past or Current and include date of onset.

Respiratory

- **Please mark C or P: Currently (C) or In the past (P)?**

Asthma

Bronchitis

Chronic Sinusitis

Emphysema

Pneumonia

Sleep Apnea

Tuberculosis

Other Respiratory conditions (please list):

Inflammatory/Autoimmune

- **Please mark C or P: Currently (C) or In the past (P)?**

Chronic Fatigue Syndrome

Epstein-Barr Virus

Graves Disease

Gout

Hashimoto's thyroiditis

Herpes

Lupus SLE

Poor Immune Function (frequent infection)

Rheumatoid Arthritis

Other Inflammatory/Autoimmune conditions (please list):

Musculoskeletal/Pain

- **Please mark C or P: Currently (C) or In the past (P)?**

Chronic Pain

Fibromyalgia

Migraines

Osteoarthritis

Other Musculoskeletal/Pain conditions (please list):

Cardiovascular

- **Please mark C or P: Currently (C) or In the past (P)?**

Atherosclerosis

Elevated cholesterol

Heart attack

High blood pressure

Irregular heart beat

Mitral Valve Prolapse

Other Cardiovascular conditions (please list):

Neurological/Brain

- **Please mark C or P: Currently (C) or In the past (P)?**

ADD/ADHD

Alzheimer's disease

ALS

Anorexia

Anxiety

Mitral Valve Prolapse

Asperger's diabetes

Autism

Bulimia

Eating disorder, Unspecified

Memory problems

Parkinson's disease

Seizures

Stroke

Other Neurological/Brain conditions (please list):

Urinary/Gynecological (For men and women)

- **Please mark C or P: Currently (C) or In the past (P)?**

Kidney Stones

Prostate problems

Urinary tract infection (UTI)

Yeast Overgrowth/Infection

Other Urinary/Gynecological conditions (please list):

Cancer(s)

Type:

Treatment:

Metabolic/Endocrine For men and women

- **Please mark C or P: Currently (C) or In the past (P)?**

Diabetes Type 1

Diabetes Type 2

Hypoglycemia

Hypothyroidism (low thyroid)

Hyperthyroidism (overactive thyroid)

Infertility

Metabolic Syndrome(pre-diabetes, insulin resistance)

Polycystic Ovarian Syndrome (PCOS)

Other Metabolic/Endocrine conditions (please list):

Dermatological For men and women

- **Please mark C or P: Currently (C) or In the past (P)?**

Acne

Eczema

Psoriasis

Rosacea

Skin Rash

Other Dermatological conditions (please list):

Describe any additional medical or health problem concerns:

Oral History

Do you visit a dentist regularly (twice per year, please circle)? Yes * No

Do you have any silver/mercury amalgam fillings(please circle)? Yes * No

How many?

Do you have any? (please circle)

Gold fillings * Root canals * Implants * Bridges * Crowns

Do you have? (please circle)

Tooth pain * Bleeding gums * Gingivitis * Chewing problems * TMJ * Oral thrush * Swallowing problems * Other (please describe below)

If other, please describe:

Surgeries/Hospitalizations

Please list any previous injuries, surgeries, and hospitalizations; provide the date and your age, if known:

Diagnostic Studies

Please list any diagnostic studies. Example: CT scan, MRI, bone density, colonoscopy, etc, and provide data and age if known:

Birth History

Your Birth:

Natural/Vaginal * C-Section * Unknown

Were you breastfed as an infant? Yes * No

How would you rate your health as a child?

Good * Fair * Poor

Medications & Supplements Please list all prescription medications and nutritional supplements, herbs/botanicals you are currently taking with the year started.

Medications

Medication Name	Dose	Frequency	Reason	Notes:

Supplements

Supplement Name	Dose	Frequency	Reason	Notes:

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, Aspirin): Yes or No

Have you had prolonged or regular use of Tylenol? Yes * No

Have you had prolonged use or regular use of opioid painkillers? Yes * No

Have you had prolonged or regular use of PPI's (Previcid, Nexium, etc.) or acid-blocking Drugs (Tagamet)? (Please list):

Frequent antibiotics >3 times per year? Yes * No

Long term antibiotics? Yes or No

CBD

Have you ever taken CBD before?

If so, what ailment were you trying to treat?

What type of CBD did you take? (method of administration) (Tincture, Supplement, Sauve, Vape, etc)

How frequently did you take it?

How many milligrams did you take/use? How many times per day?

Where did you buy your CBD?

Did you have success with the CBD or do you need advice from a coach regarding how to take it and how much to take?

Please add any comments about how it made you feel and if you'd use it again, etc. or anything at all:

Nutrition History

Have you ever had a nutrition consultation? Yes or No

If yes, date & describe outcome:

Have you made any changes in your eating habits because of your health? Yes * No

Please describe:

Do you currently follow a special diet or nutritional program? Yes * No

Please describe:

Do you avoid any particular foods? Yes * No

Please describe:

Height & Weight

Height:_____

Current weight:_____

Waist (inches):_____

Weight 1 year ago:_____

Hip (inches):_____

Usual Weight:_____

Desired/goal weight:_____

Have you had any recent history of weight loss or weight gain? Yes * No

If yes, please describe.

Does your weight affect how you feel about yourself? Yes or No

Please comment:

Number of meals eaten per day (circle one):

1 meal per day 2 meals per day 3 meals per day

Number of snacks eaten per day (circle):

None 1 2 3 >3

What % of meals do you eat out per week? (circle)

>75% 50-75% 25-50% < 25%

Meal most often eaten out:

Breakfast Dinner Lunch

Types of eating establishments most often frequented:

Do you avoid any particular foods or beverages? Yes No

If yes, describe what and why:

What are your comfort foods ?

Do you crave any foods?

Are there special textures you prefer? Or avoid certain textures for a particular reason? Please describe:

What is your average daily water consumption (8 ounce glass)?

6-8 4-6 2-4 <2

Check all the factors that apply to your eating habits and lifestyle:

Fast eater

Live or often eat alone

Erratic eating patterns

Time constraints

Eat too much/overeat

Drink too much alcohol

Late night eating

Addicted to sugar/sweets

Rely on convenience items

Eat too many processed carbs (breads, pastas, chips, etc.)

Associate symptoms with eating

Struggle with eating issues

Negative relationship with food

Emotional eating

Dislike healthy food

Eat fast food frequently

Organic food is important to me

Poor snack choices

Love to eat

Do not plan meals or menus

Love to cook

Travel frequently

Family members have different dietary needs

Confused about nutrition advice? Please explain

Please note any additional comments about your Nutrition/eating habits :

Lifestyle/Activity

Do you engage in moderate cardiovascular physical activity for a minimum duration of 20 minutes at least 3 days a week? For example: brisk walking, jogging, hiking, cardio exercise

Low Intensity
Moderate intensity
High intensity

Duration:
# of days per week:
# of minutes per workout day:

Do you participate in any of the following activities:

Stretching/Yoga

Cardio/Aerobics

Strength Training

Sports or Leisure

Note any problems that limit your physical activity.

Do you smoke? Yes * No

Do you chew tobacco? Yes * No

How many years?

Packs per day?

Secondhand smoke exposure? Yes * No

Do you currently use any of the following (i.e. marijuana, cocaine, crack, heroin, speed, etc.) (please remember this information is totally private between only you and I).

If yes, please describe the type of drugs?

How often do you use them?

Daily Stressors Rate on a scale of 1 (low) to 10 (high)

Work

Family

Social

Finances

Health

Excess stress in your life? Yes No

Do you easily handle stress? Yes No

How do you handle stress, what relaxes you?

Do you feel your life has meaning and purpose? Yes No Not sure

Do you believe stress is presently reducing the quality of your life? Yes No

Average number of hours you sleep per night during the week?

<6

6-8

8-10

10+

Average number of hours you sleep per night during the weekends?

<6

6-8

8-10

10+

Trouble falling asleep? Yes No

Rested upon waking? Yes No

Do you wake up during the night? Yes No

How many times?

How would you rate the overall quality of your sleep?

1 2 3 4 5

1 = Low, 5 = High

Environmental History

Do you experience or have you been diagnosed with chemical Sensitivities? Yes No

Please describe symptoms.

What is your occupation?

Are you exposed regularly to any of the following? Check all that apply:

Aluminum cookware

Heavy metals

Auto exhaust/fumes

Mold

Chemicals

Paint fumes

Cigarette smoke

Pesticides

Cosmetics: nail polish / hair dyes/perfumes

Pet dander

Dry-cleaned clothes

Fertilizers

Other

Please describe any significant past exposure to harmful chemicals/substances.

Readiness Assessment

What do you think would make the most difference in your overall health?

In order to improve your health, how willing are you to: Rate on a scale of 5 (very willing) to 1 (not willing)

Significantly modify your diet

Keep a record of everything you eat each day

Modify your lifestyle (e.g., work demands, sleep habits, exercise)

Engage in regular exercise/physical activity

Practice a daily relaxation techniques

Take nutritional Supplements as recommended

Have periodic lab tests to assess your progress

Comments:

Digestive History

DIRECTIONS:

This questionnaire asks you to assess how you have been feeling during the last four months. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, indicate the number that best describes your symptoms:

0 = No or Rarely- You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant. (monthly or less)

1 = Occasionally- Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = Often- Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently- Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Section A

0 = No or Rarely / 1 = Occasionally / 4 = Often / 8 = Frequently

Indigestion, food repeats on you after you eat Bad taste in your mouth Excessive burping, belching and/or bloating following meals Small amounts of food fill you up immediately Stomach

spasms and cramping during or after eating Skip meals or eat erratically because you have no appetite. A sensation that food just sits in your stomach creating uncomfortable fullness and bloating, pressure and bloating during or after a meal.

Total Points

Section B

0 = No or Rarely / 1 = Occasionally / 4 = Often / 8 = Frequently

Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt.

Digestive problem that subsite with rest and relaxation

Feel hungry an hour or two after eating a good sized meal

Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache.

Stomach pain, burning and/or aching over a period of 1-4 hours after eating

Feel a sense of nausea when you eat

Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk or taking antacids.

Difficulty or pain when swallowing food or beverage

Burning sensation in the lower part of your chest, especially when lying down or bending forward.

Total Points:

Section C

0 = No or Rarely / 1 = Occasionally / 4 = Often / 8 = Frequently

When massaging under your rib cage on your left side, there is pain, tenderness or soreness.

Stool odor is embarrassing Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal.

Undigested food in your stool

Lower abdominal discomfort is relieved with the passage of gas or withi a bowel movement.

Three or more large bowel movements daily

Specific foods/beverages aggravate indigestion

Diarrhea (frequent loose, watery stool)

The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day.

Bowel movement shortly after eating (within 1 hr.)

Total Points

Section D

0 = No or Rarely / 1 = Occasionally / 4 = Often / 8 = Frequently

Discomfort, pain or cramps in your colon (lower abdominal area) Alternate between constipation and diarrhea

Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas.

Rectal pain, itching or cramping

Generally constipated (or straining during bowel movements)

No urge to have a bowel movement

Stool is small, hard and dry

An almost continual need to have a bowel movement Pass mucus in your stool

Total Points:

Digestive History Key:

0-15 - mild GI issues 16-50 - moderate GI issues > 51 - significant GI issues

Patient Narrative

Tell me your story Please write a summary of any information that will be helpful to me regarding your health and medical history or in your own words:

My Symptom Questionnaire (MySQ)

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale: 0 = Never 1 = Rarely, Effect not severe 2 = Occasionally, Effect not severe 3 = Occasionally, Effect severe 4 = Frequently, Effect not severe

5= Frequently, Effect severe

Head

Headaches Faintness

Dizziness

Total

Nose

Stuffy nose Sinus problems

Hay fever Sneezing attacks

Excessive mucus formation Loss sense of smell

Total

Nails

Spoon shaped Brittle, cracking

Discolored White spots

Lines/Stripes

Total

Hair

Hair thinning

Hair loss

Loss of outer eyebrow hair

Premature greying

Easy hair pluckability

Total:

Skin

Acne Hives, rashes

Dry skin

Bumps on back of arms

Flushing

Excessive sweating

Total:

Immune

Colds Flu

Chronic infections

Total:

Genitourinary

Frequent or urgent urination

Itching

Discharge Incontinence

Total:

Eyes

Watery/itchy eyes

Yellowing eyes

Swollen, reddened, sticky eyelids

Bags, dark circles

Night vision problems

Blurred vision

Loss peripheral vision

Total:

Mouth/Throat

Chronic coughing

Gagging frequently, throat clearing.

Sore throat

Hoarseness

Swollen/discolored tongue

Burning tongue

Coating on tongue

Chewing problems

Canker Sores

Fever blisters

Cracks corner of mouth

Total:

Heart

Irregular/skipped beats

Rapid/ pounding beats

Chest Pain

Total:

Lungs

Chest Congestion

Asthma or bronchitis

Shortness of breath

Difficulty Breathing

Total:

Energy/Sleep

Fatigue

Lethargy

Hyperactivity

Insomnia

Sleep disruptions

Total:

Neurological

Poor memory

Confusion

Poor concentration/brain fog

Poor physical coordination

Loss of balance

Tingling in hands or feet

Stuttering or stammering

Slurred speech

Total:

Ears

Itchy Ears,

Earaches, ear infections

Drainage from ear

Ringing

Hearing loss

Total

Digestive Tract/Gastrointestinal (GI)

Nausea

Vomiting

Diarrhea

Constipation

Alternating diarrhea & constipation

Bloating

Belching Gas/flatulence

Heartburn

Upper GI pain

Lower abdominal pain

Total:

Joints/Muscle/Bone

Pain or aches in joints

Arthritis

Stiffness/limited movement

Pain or aches in muscles

Feeling of weakness or loss of strength

Restless legs

Bone pain

Broken bones

Total

Weight

Underweight

Overweight

Obese Weight loss (>5-10 lbs)

Weight gain (>5-10 lbs)

Fluid retention

Total

Emotions

Mood Swings

Anxiety, worry, fear, nervousness

Anger, irritability, agitation

Depression

Total:

Grand Total Key: the higher the score, the greater the impact on the individual.

0-15 Fair

16-25 Moderate

26-50

Major >50 Severe

3-Day Food Journal

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Food Journal for three consecutive days including one weekend day. Please do not change your eating habits at this time, as the purpose of this food record is to analyze your current diet. Record information as soon as possible after the food has been consumed. Describe all foods and beverages consumed as accurately and in as much detail as possible including estimated amounts, brand names, cooking method, etc. Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, 1⁄2 cup, 1 teaspoon, etc. qInclude any added items, for example: tea with 1 teaspoon of honey, potato with 2 teaspoons butter, etc. List all beverages and types, including water, coffee, tea, sports drinks, sodas/diet sodas, etc. Comment on any emotional or physical symptoms experienced including hunger level, stress, bloating, fatigue, adverse reaction(s) experienced, timing of adverse reactions, etc. Include comments about eating habits and environment such as reasons for skipping a meal, when a meal was eaten at a restaurant, etc. and any additional details that may be important Each day note all bowel movements, describe their consistency (regular, loose, firm, etc.), frequency, and any additional information.

If you use an online food journ32

Day 1 Food Journal

Meal	Date/Time	Food	Beverages	Symptoms
Breakfast				
Snack				
Lunch				
Snack				
Dinner				

Day 1 Elimination Journal

Time Description

Elimination

Elimination

Elimination

Day 2 Food Journal

Meal	Date/Time	Food	Beverages	Symptoms
Breakfast				
Snack				
Lunch				
Snack				
Dinner				

Day 2 Elimination Journal

Time Description

Elimination

Elimination

Elimination

Day 3 Food Journal

Meal	Date/Time	Food	Beverages	Symptoms
Breakfast				
Snack				
Lunch				
Snack				
Dinner				

Day 3 Elimination Journal

	Time	Description
Elimination		
Elimination		
Elimination		

For more information please visit our site at www.cbdtrainingacademy.com