

Beyond Wellness

Dr. Lorraine Johnson

4501 Pacific Coast Highway Suite 300 Long Beach, CA 90804

Ph. (562) 498-2277

Fax (562) 494-7454

SUBJECTIVE QUESTIONNAIRE

Weight_____ Height_____ Blood Pressure (if known)_____ % Body Fat (if known)_____

REVIEW OF SYMPTOMS:

Circle only those items with which you identify, past or present. Ignore anything that does not apply to you.

GENERAL:			Indecisive	Now	Past
Fever	Now	Past	Face Twitch	Now	Past
Chills	Now	Past	Poor Memory	Now	Past
Aches/Pains	Now	Past	Hair Loss	Now	Past
General Weakness	Now	Past	Pressure	Now	Past
Difficulty Sweating	Now	Past	EYES:		
Swollen Glands	Now	Past	Sand In Eyes	Now	Past
SKIN:			Double Vision	Now	Past
Cuts Heal Slowly	Now	Past	Blurred Vision w/o Glasses	Now	Past
Bruise Easily	Now	Past	Poor Night Vision	Now	Past
Rash	Now	Past	Bright Flashes	Now	Past
Pigmentation	Now	Past	Halos Around Lights	Now	Past
Changing Moles	Now	Past	Eye Pains	Now	Past
Other Skin Problems	Now	Past	Dark Circles Under Eyes	Now	Past
Nails Split	Now	Past	Strong Light Irritates	Now	Past
White Spots/Lines on Nails	Now	Past	Watery Eyes	Now	Past
Crawling Sensation	Now	Past	Cataracts	Now	Past
Burning on Bottom of Feet	Now	Past	Floaters In Eyes	Now	Past
HEAD:			EARS:		
Poor Concentration	Now	Past	Aches	Now	Past
Confusion	Now	Past	Discharge	Now	Past
Headaches	Now	Past	Pains	Now	Past
After Meals	Now	Past	ringing	Now	Past
Severe	Now	Past	Buzzing	Now	Past
Migraine Type	Now	Past	Deafness	Now	Past
Frontal	Now	Past	Itching	Now	Past
Afternoon	Now	Past	NOSE:		
Occipital	Now	Past	Stuffy	Now	Past
Daytime	Now	Past	Bleeding	Now	Past
Nighttime	Now	Past	Running	Now	Past
Relieved By:			Discharge	Now	Past
Eating Sweets	Now	Past	Watery Nose	Now	Past
Concussion/Whiplash	Now	Past	Block	Now	Past
Mental Sluggishness	Now	Past	Infection	Now	Past
Forgetfulness	Now	Past	Polyps	Now	Past

SINUSES:		
Draining	Now	Past
Infections	Now	Past
Trouble	Now	Past

MOUTH:		
Coated Tongue	Now	Past
Sore Tongue	Now	Past
Tooth Problems	Now	Past
Bleeding Gums	Now	Past
Tongue (Geographic)	Now	Past
Mouth Problems	Now	Past
Canker Sores	Now	Past

THROAT:		
Mucus	Now	Past
Difficulty Swallowing	Now	Past
Frequent Hoarseness	Now	Past
Tonsillitis	Now	Past
Enlarged Glands	Now	Past
Soreness	Now	Past

NECK:		
Stiffness	Now	Past
Swelling	Now	Past
Lumps	Now	Past

CIRCULATION/RESPIRATION:		
Swollen Ankles	Now	Past
Sensitive to Hot	Now	Past
Sensitive to Cold	Now	Past
Extremities Cold/Clammy	Now	Past
Hands/Feet go to Sleep	Now	Past
High Blood Pressure	Now	Past
Chest Pain	Now	Past
Pain Between Shoulders	Now	Past
Dizziness on Arising	Now	Past
Fainting	Now	Past
High Cholesterol	Now	Past
Numbness	Now	Past
Wheezing	Now	Past
Irregular Heartbeat	Now	Past
Heart Flutters	Now	Past
Low Exercise Tolerance	Now	Past
Frequent Coughs	Now	Past
Cough Up Blood	Now	Past
Breathing Heavily	Now	Past
Dizziness or Faintness	Now	Past
Sigh Frequently	Now	Past
Shortness of Breath	Now	Past
Night Sweats	Now	Past

NEURO-MUSCULAR:		
Can't Go To Sleep	Now	Past
Can't Stay Asleep	Now	Past
Poor Memory	Now	Past
Speech Problems	Now	Past
Leg or Arm Weakness	Now	Past
Balance Problems	Now	Past

GASTROINTESTINAL/DIGESTION:		
Canker Sores	Now	Past
Poor Smell/Taste	Now	Past
Gas	Now	Past
Ulcers	Now	Past
Poor Appetite	Now	Past
Excessive Appetite	Now	Past
Gall Bladder Attacks or Stones	Now	Past
Nervous Stomach	Now	Past
Full Feeling After Meals	Now	Past
Indigestion	Now	Past
Heartburn	Now	Past
Nausea	Now	Past
Vomiting	Now	Past
Vomiting Blood	Now	Past
Abdominal Pains or Cramp	Now	Past
Abdominal Distension	Now	Past
Diarrhea	Now	Past
Constipation	Now	Past
Bowel Habit Changes	Now	Past
Rectal Bleeding	Now	Past
Tarry Stools	Now	Past
Laxative Use Often	Now	Past
Incomplete Bowel Evacuation	Now	Past
Rectal Itch	Now	Past

KIDNEY/URINARY TRACT:		
Burning Sensation	Now	Past
Frequent Urination	Now	Past
Blood in Urine	Now	Past
Night Time Urination	Now	Past
Problem Passing Urine	Now	Past
Trouble Controlling Urine	Now	Past
Kidney Pain	Now	Past

GENITALIA:		
Male:		
Lumps in Testicles	Now	Past
Sore on Penis	Now	Past
Penis Discharge	Now	Past
Erection Problems	Now	Past
Diminished Sex Drive	Now	Past
Hernia	Now	Past

Female:		
Fibroid Breasts	Now	Past
Breast Lumps	Now	Past
Nipple Discharge	Now	Past
Vaginal Itching	Now	Past
Vaginal Discharge	Now	Past
Non-Period Bleeding	Now	Past
Spotting	Now	Past
Hot Flashes	Now	Past
Diminished Sex Desire	Now	Past
Pain with Intercourse	Now	Past
Change in Periods	Now	Past
Pain other than w/Period	Now	Past
Endometriosis	Now	Past
Possible Pregnancy	Now	Past

Muscle Cramping Tight Now Past

GENITALIA:

Female:

Diminished Sex Desire Now Past
Pain with Intercourse Now Past
Change in Periods Now Past
Pain other than with period Now Past
Endometriosis Now Past
Possible Pregnancy Now Past

NUTRITIONAL:

Strong Appetite For:

Sweets Now Past
Fruits Now Past
Vinegar Now Past
Bread Now Past
Ketchup Now Past
Mustard Now Past
Spices Now Past
Coffee Now Past
Cola Now Past
Tea Now Past
Salt Now Past
Alcohol Now Past
Drugs Now Past

Abnormal Thirst Now Past
Brown Spots or Bronzing of Skin Now Past
Can't Work Under Pressure Now Past
Chronic Fatigue Now Past
Daytime Sleepiness Now Past
Sleepy After Meals Now Past

PSYCHOLOGICAL:

Is Your Life:

Satisfactory Now Past
Boring Now Past
Demanding Now Past
Unsatisfactory Now Past

Do You Worry Over:

Home Life Now Past
Marriage Now Past
Children Now Past
Job Now Past
Income Now Past
Money Problem Now Past

Do You Often:

Feel Depressed Now Past
Have Anxiety Now Past
Have Irrational Fears Now Past
Feel Upset Now Past
Feel Things Go Wrong Now Past
Feel Shy Now Past
Cry Now Past
Feel Inferior Now Past

Have You:

Seriously Considered Suicide Now Past
Attempted Suicide Now Past

STRUCTURAL:

Head Injury Now Past
Concussion Now Past
Neck Stiffness Now Past
Low Back Stiffness Now Past
Joint Pains Now Past
Joint Swelling Now Past
Muscle Weakness Now Past
Muscle Lumps/Swelling Now Past
Muscle Stiffness Now Past
Bump on Bones Now Past
Damp Weather Bothers You Now Past
Mobility Problems Now Past
Other Now Past

FEELINGS PRE & POST MEALS:

Pulse Speeds After Meals Now Past
Inward Trembling Now Past
Irritable Before Meals Now Past
Hungry right after meals Now Past
Feel pickup after exercising Now Past
Easily Fatigued Now Past

MEDICAL PROBLEMS:

Anorexia Now Past
Acne Now Past
Asthma Now Past
Abnormal Chest X-Ray Now Past
Abnormal Electrocardiogram Now Past
Angina Pectoris Now Past
Abnormal Stomach X-Ray Now Past
Anemia (Type:) Now Past
Appendicitis Now Past
Arthritis Now Past
Bulimia Now Past
Blindness, Either Eye Now Past
Broken Bones Now Past
Cataracts Now Past
Chronic Bronchitis Now Past
Cirrhosis Now Past
Colon or Bowel Trouble Now Past
Deafness Now Past
Diabetes Now Past
Dysentery Now Past
Ear Infection Now Past
Emphysema Now Past
Enlarged Hear Now Past
Glaucoma Now Past
Gallstones Now Past
Gout Now Past
Goiter Now Past
Gonorrhea Now Past
Hay Fever Now Past
Heart Murmur, as an adult Now Past
Heart Attack Now Past
High Blood Pressure Now Past
Hepatitis Now Past
Hemorrhoids Now Past
Kidney Stones Now Past

Mononucleosis Now Past

MEDICAL PROBLEMS: CONT.

Nervous Breakdown Now Past
Obesity Now Past
Parasites Now Past
Poor Blood Clotting Now Past
Polio Now Past
Phlebitis Now Past
Rheumatic Fever Now Past
Rectal Trouble Now Past
Recurrent Boils Now Past
Silver (Amalgam) Fillings Now Past
Stroke Now Past
Stomach or Duodenal Ulcer Now Past
Syphilis Now Past
Skin Disease Now Past
Serious Depression Now Past
Serious Emotional Problems Now Past
Toe Fungus Now Past
Tuberculosis Now Past
Thyroid Overactivity Now Past
Thyroid Underactivity Now Past
Varicose Veins Now Past
Venereal Disease Now Past
Warts Now Past
Beer: Ounces/Day () Now Past
Hard Liquor: Ounces/Day () Now Past
Narcotic Drugs Now Past
Do You Use:
Vitamins Now Past
Nail Polish Now Past
Cosmetics Now Past
Lotions Now Past
Regular Exercise Now Past
Infectious Diseases:

Surgeries:

Hospitalization(s):

BIRTH FACTORS:

C-Section Yes No
Premature Yes No
Forceps Delivery Yes No
Breach Delivery Yes No
Bottle-Fed Yes No
Breast-Fed Yes No
Birth Trauma: (Describe)

ALLERGIES/SENSITIVITIES:

Pollen Now Past
Molds Now Past
Foods Now Past
Carpet/Furniture Now Past
Fumigation Now Past
Pesticides Now Past
Smoke Now Past
Chemicals Now Past
Computer CRT's Now Past
Live Near Power Lines Now Past
Penicillin Now Past
Sulfa Now Past
Aspirin Now Past
Bufferin Now Past
Fluids Now Past
Dusts Now Past
Fabric Now Past
Metals Now Past

MEDICATIONS:

(List Name Of All Medications)

Insulin Now Past
Thyroid Now Past
Blood Pressure Now Past
Hormones Now Past
Birth Control Pills Now Past
Digitalis Now Past
Other Now Past

PERSONAL HABITS:

Smoke: Packs/Day () Now Past
Coffee: Cups/Day () Now Past

DENTAL:

Root Canal Yes No
If Yes, How Many? _____
If Yes, When? _____
Teeth Extracted? Including
Wisdom Teeth Yes No
If Yes, When? _____
Bridges In Mouth Yes No
If Yes, Material Used?
Fillings Yes No
If Yes, Material Used?

ENVIRONMENTAL FACTORS:
 Briefly describe where you have lived since
 childhood.

ELECTROMAGNETIC/RADIATION:
 Lived Under or Near Electric
 Transmission Wires Yes No
 Work with Computers Yes No
 If Yes on the Above Two,
 How Long? -----
 When? -----
 Describe any other exposure to
 Electromagnetic Radiation sources:

DENTAL: CONT.
 Crowns Yes No
 If Yes, Material Used?

 Braces Yes No
 If Yes, Material Used?

 Splint Yes No
 If Yes, Material Used?

 TMJ (jaw problems) Yes No
 If Yes, Describe...

 What is your Heritage? (Irish, German, Spanish...)

Check off any of the following that apply to you within the last 30 days:

- | | |
|--|--|
| _____ Do you feel nauseous? | _____ Do you have abdominal/intestinal pain? |
| _____ Do you have bloating? | _____ Do you get bloated after meals? |
| _____ Do you get heartburn? | _____ Do you have diarrhea? |
| _____ Do you have constipation? | _____ Do you travel outside the U.S.? |
| _____ Do you have gas? | _____ Are your stools compact/hard to pass? |
| _____ Do you belch following meals | _____ Do you have gurgles in your stomach? |
| _____ Do your bowel movements alternate between constipation and diarrhea? | |

Are you currently taking nutritional supplements? Yes_____ No_____

If Yes, please list all products and daily dosages (print clearly):

WORK HISTORY

Dates: _____ Type of Work: _____

Description of Duties/Tasks:

Dates: _____ Type of Work: _____

Description of Duties/Tasks:

Dates: _____ Type of Work: _____

Description of Duties/Tasks:

Describe any believed exposure(s) to environmental and/or chemical toxins:

Describe your hobbies and forms of recreation:

