

**Fibromyalgia-Chronic Fatigue New Patient**  
**Confidential Questionnaire**

**Fibromyalgia Solutions Center of the Triad**

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Please briefly describe your health problems:

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When was the last time you really felt good {date}? \_\_\_\_\_ Were you healthy as a child? Yes \_\_\_ No \_\_\_

If not please list health problems you had as a child--

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What caused your PRESENT illness? Were there significant event{s} that you feel trigger your health condition? For example...Family Problems, Job Stress, Injuries-Accidents, Relationships, Physical Abuse, Emotional Abuse, Please briefly explain:

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Have you ever been diagnosed with Fibromyalgia or Chronic Fatigue Syndrome? Yes \_\_\_ No \_\_\_ If yes, which one or both? \_\_\_\_\_

Date of Diagnosis \_\_\_\_\_ Who Diagnosed you?

What type of doctor made diagnosis {family doctor, rheumatologist, OBGYN, orthopedic doctor, etc.}? \_\_\_\_\_

What makes your health problems worse? Stress, weather changes, poor sleep, exertion, etc.

**Sleep**

Do you have trouble falling asleep? Yes \_\_\_ No \_\_\_

Do you have trouble staying asleep? Yes \_\_\_ No \_\_\_

Do you wake up exhausted? Yes \_\_\_ No \_\_\_

When did you first start having trouble sleeping {months, years}? \_\_\_\_\_

Are you currently taking any sleep medication? \_\_\_\_\_

**Neurotransmitters**

What over the counter or prescription medications have you taken for sleep?

\_\_\_Ambien \_\_\_Zanaflex \_\_\_Trazadone \_\_\_Sonata \_\_\_Tylenol PM \_\_\_Elavil  
\_\_\_Neurontin

\_\_\_Doxepin \_\_\_Flexeril \_\_\_Xanax \_\_\_Klonopin \_\_\_Ativan \_\_\_Melatonin \_\_\_5HTP  
\_\_\_Benadryl \_\_\_Others

Please list others here:

\_\_\_\_\_

Are you taking anti-depressants? Yes \_\_\_ No \_\_\_ Which ones and for how long?

\_\_\_\_\_

Have you taken any anti-depressants in the past? Yes \_\_\_ No \_\_\_

Which ones?

Prozac \_\_\_ Paxil \_\_\_ Celexa \_\_\_ Lexapro \_\_\_ Wellbutrin \_\_\_ Effexor \_\_\_ Zoloft \_\_\_

Were they helpful? Please describe {didn't help, had side-effects, stopped working, etc.}

\_\_\_\_\_

\_\_\_\_\_

Are you currently seeing a Psychiatrist? Yes \_\_\_ No \_\_\_ If so, who? \_\_\_\_\_

**Digestion**

Do you have normal daily bowel movements {at least one bowel movement a day}?  
Yes\_\_\_ No\_\_\_

If no, Do you have loose bowels {diarrhea}, constipation, or both? \_\_\_\_\_

Have you been diagnosed with Irritable Bowel Syndrome {IBS}? Yes\_\_\_ No\_\_\_

Do you have indigestion, heartburn, gas or bloating? Yes\_\_\_ No\_\_\_

Are you on digestion medication? If so, please list \_\_\_\_\_

Do you crave carbohydrates or sugar? Yes\_\_\_ No\_\_\_

Are there certain foods that give you problems {sugar, spicy foods, fruits, meats, fats, dairy, etc.}? Please List \_\_\_\_\_

**Immune Function**

Do you have problems with: Please check those that apply?

- |                                                                  |                                                 |
|------------------------------------------------------------------|-------------------------------------------------|
| ___ Chronic Sinus Congestion                                     | ___ Chronic Sinus Infections {2 or more a year} |
| ___ Chronic Sore Throats                                         | ___ Chronic Colds or Flu infections each year   |
| ___ Chronic Upper Respiratory Infections {Bronchitis, Pneumonia} |                                                 |

**Liver Function**

Have you ever had elevated or high liver enzymes on laboratory blood work? Yes\_\_\_  
No\_\_\_ Not Sure\_\_\_

Do you have any funny reactions if you drink alcohol {little goes a long way, can't drink red wine, etc.} If so, please describe \_\_\_\_\_  
\_\_\_\_\_

Do you have any problems eating raw onions? Yes\_\_\_ No\_\_\_

If you eat asparagus, the day after do you get a very strong odor when urinating {the next day?} Yes\_\_\_ No\_\_\_

Do you have hepatitis? Yes\_\_\_ No\_\_\_ If yes, type? \_\_\_\_\_

Do you have a fatty liver? Yes\_\_\_ No\_\_\_ Not Sure?\_\_\_

Do you have funny reactions to medication? Yes\_\_\_ No\_\_\_ If yes, please Explain

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Do strong odors {gasoline, cleaning supplies, perfume, etc.} bother you? Yes\_\_\_ No\_\_\_

**Adrenal Function**

If you skip a meal do you feel bad {have headaches, become irritable, get jittery, tired, etc.} Yes\_\_\_ No\_\_\_

Do you have low blood pressure? Yes\_\_\_ No\_\_\_

Do you crave salty foods? Yes\_\_\_ No\_\_\_

Does increased stress or stressful situations make your symptoms worse? Yes\_\_\_ No\_\_\_ \

How's your Energy Level? Choose 1 to 10 with 10 being the best. \_\_\_\_\_

How do you feel in the morning? \_\_\_Refreshed \_\_\_Hung over \_\_\_Exhausted  
\_\_\_Nauseated \_\_\_Achy all over

Are you hungry in the morning? Yes\_\_\_ No\_\_\_

Do you remember having Mononucleosis or the Epstein-Barr Virus?

**Stress**

Have you ever been physically, emotionally or sexually abused as a child or adult?  
Yes\_\_\_ No\_\_\_ If yes, please list but you do not need to provide details. \_\_\_\_\_

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Have you ever been divorced? Yes\_\_\_ No\_\_\_ If so, how many times? \_\_\_\_\_

If you have been divorced please provide the year and were they friendly or not?

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If you have children, are your relationships stressful or good? \_\_\_\_\_

Have you had any deaths that have affected you? \_\_\_\_\_

Any serious accidents or injuries? \_\_\_\_\_

Do you currently have or in the past had a lot of job stress? Yes\_\_\_ No\_\_\_  
\_\_\_\_\_

Are you currently working? Yes\_\_\_ No\_\_\_ Are you on disability? Yes\_\_\_ No\_\_\_

If other major stressful events, please list? Looking for events and time frames:  
\_\_\_\_\_  
\_\_\_\_\_

**Fibro Fog**

Are you noticing that you are becoming more absentminded? Yes\_\_\_ No\_\_\_

Is it harder for you to concentrate? Yes\_\_\_ No\_\_\_

Are your thoughts becoming more difficult to express? Yes\_\_\_ No\_\_\_

Are these symptoms getting worse? Yes\_\_\_ No\_\_\_

Do you sometimes feel spaced-out? Yes\_\_\_ No\_\_\_

**Diet**

What do you eat for Breakfast? Please {honestly} describe here: \_\_\_\_\_  
\_\_\_\_\_

What do you eat for Lunch? \_\_\_\_\_  
\_\_\_\_\_

What do you eat for Dinner? \_\_\_\_\_  
\_\_\_\_\_

What are your usual snack foods {popcorn, ice cream, cookies, potato chips, candies}?  
Please be honest and specific: \_\_\_\_\_  
\_\_\_\_\_

Do you drink coffee? Yes\_\_\_ No\_\_\_ If so, how many cups a day and when? \_\_\_\_\_

Do you drink sodas and tea? Yes\_\_\_ No\_\_\_ If so, how many glasses and when? \_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Yes\_\_\_ No\_\_\_

**Pain**

**Where do you have pain?** Joint\_\_ Muscle\_\_ Neck\_\_ Shoulder\_\_ Mid Back\_\_ Low Back\_\_ Chest\_\_ Hips\_\_ Arms\_\_ Back of legs\_\_ Front of legs\_\_ Knees\_\_ Feet\_\_ Ankles\_\_ Hands\_\_ Fingers\_\_ Head\_\_

How long have you had this pain? \_\_\_\_\_

If you had to choose, which bothers you worse, your neck or your back? \_\_\_\_\_

Does your pain radiate? Yes\_\_ No\_\_ If so, where? \_\_\_\_\_

Are you sensitive to touch? Yes\_\_\_ No\_\_\_

Do you have headaches? Yes\_\_\_ No\_\_\_ If so, describe them and how long have you had them and how often do you get them? \_\_\_\_\_

Do you get dizzy, nauseated or lightheaded? Yes\_\_ No\_\_

On a scale of 1-10, with 10 being the worse, please rate your pain \_\_\_\_\_

Is your pain progressively getting worse? Yes\_\_\_ No\_\_\_

**Please place a check mark by any of the below that applies to you.**

**HEENT:** Headaches\_\_ Vision Problems\_\_ Frequent Colds/Sore Throats\_\_  
Dizziness\_\_ Hearing Problems\_\_  
Chemical Sensitivities/Allergies: \_\_\_\_\_

**CVS:** Chest Pain\_\_ Palpitations\_\_ High Cholesterol\_\_ High Blood Pressure\_\_

**LUNGS:** Coughing\_\_ Wheezing\_\_ Breathing Problems\_\_ Frequent Respiratory Infections\_\_

**GI:** Swallowing Problems\_\_ Stomach Pains\_\_ Nausea\_\_ Vomiting\_\_ Diarrhea\_\_  
Constipation\_\_ Digestive Difficulties\_\_

**Food Allergies** Yes\_\_ No\_\_ \_\_\_\_\_

**GU:** Urinary Frequency\_\_ Urinary Hesitancy\_\_ Irregular Periods\_\_ Bladder Infections\_\_ Decreased Sex Drive\_\_

**SKIN:** Rash\_\_ Dry Skin\_\_ Fungus Infections\_\_ Eczema\_\_ Psoriasis\_\_

**Family History:** Cancer\_\_ Diverticulitis\_\_ Thyroid\_\_ Heart Disease\_\_ Stroke\_\_  
Diabetes\_\_ High Cholesterol\_\_

**Intestinal Dysbiosis**

Have you ever been on long term {more than 2 weeks} antibiotic therapy? Yes\_\_ No\_\_

Have you ever had vaginal yeast infections? Yes\_\_ No\_\_

If yes, when was the last infection? \_\_\_\_\_

Do you have chronic vaginal yeast infections {more than 2 a year}? Yes\_\_ No\_\_

Have you been pregnant TWO or more times? \_\_\_\_\_

Have you taken birth control pills? \_\_\_\_\_ for more than 2 years?\_\_ for more than 1  
year?\_\_ 6 months to 1 year?\_\_

Are your symptoms worse on damp, muggy days or in moldy places? \_\_\_\_\_

Do you ever have itchy ears? Yes\_\_ No\_\_ Itchy nose? Yes\_\_ No\_\_ Rectal Itching?  
Yes\_\_ No\_\_

Do you crave Sugar? Yes\_\_ No\_\_ Does eating sugar make your symptoms worse? Yes\_\_  
No\_\_

Do you have rectal itching after eating sugar, fruit, or a lot of starches? Yes\_\_ No\_\_

Have you EVER been on long term {weeks} steroid therapy {Prednisone, Cortisone}?  
Yes\_\_ No\_\_

Have you EVER been on long term {month or more} non-steroidal anti-inflammatory  
medications {Vioxx, Celebrex, Naprosyn, Advil, Bextra, Mobic, etc.}? Yes\_\_ No\_\_

Do you feel “sick all over”, yet in spite of visits to different physicians, the causes  
haven’t been found? \_\_\_\_\_

## Yeast Questionnaire

Please mark you symptoms as follows: **MI**-mild **M**-moderate **S**-severe

- . Feeling of being “drained” \_\_\_\_\_
- . Abdominal pain \_\_\_\_\_
- . Constipation and/or diarrhea \_\_\_\_\_
- . Bloating, belching or intestinal gas \_\_\_\_\_
- . Indigestion or heartburn \_\_\_\_\_
- . Prostatitis \_\_\_\_\_
- . Endometriosis or infertility \_\_\_\_\_
- . Cramps and/or menstrual irregularities \_\_\_\_\_
- . Premenstrual tension {PMS} \_\_\_\_\_
- . Sore throat \_\_\_\_\_
- . Recurrent sinus infections \_\_\_\_\_
- . Chronic hives \_\_\_\_\_
- . Cough or recurrent bronchitis \_\_\_\_\_
- . Nasal congestion or postnasal drip \_\_\_\_\_
- . Nasal itching \_\_\_\_\_
- . Eczema \_\_\_\_\_
- . Psoriasis \_\_\_\_\_
- . Cystitis or interstitial cystitis \_\_\_\_\_
- . Pressure in the ears \_\_\_\_\_
- . Troublesome vaginal burning, itching or discharge \_\_\_\_\_
- . Rectal itching \_\_\_\_\_
- . Dry mouth or Throat \_\_\_\_\_
- . Mouth rashes, Including “white” tongue \_\_\_\_\_
- . Bad breath \_\_\_\_\_
- . Foot, hair or body odor not relieved by washing \_\_\_\_\_
- . Wheezing or shortness of breath \_\_\_\_\_
- . Urinary frequency or urgency \_\_\_\_\_
- . Burning on urination \_\_\_\_\_
- . Burning or tearing eyes \_\_\_\_\_

## **Thyroid**

- Fatigue
- Headaches
- Migraines
- PMS
- Irritability
- Fluid retention
- Dry hair
- Dry skin
- Hair loss
- Depression
- Decreased memory
- Decreased concentration
- Decreased sex drive
- Unhealthy nails
- Constipation
- Irritable Bowel Syndrome
- Inappropriate weight gain
- Hypoglycemia
- High Cholesterol
- Cold hands/feet
- Changes in skin pigmentation
- Changes in skin pigmentation
- Irregular periods
- Severe menstrual cramps
- Low blood pressure
- Frequent colds and sore throats
- Heat and/or cold intolerance
- Lightheadedness
- Ringing in the ears
- Infertility
- Asthma
- Low motivation
- Frequent infections
- Allergies
- Falling asleep during the day

## **Brain Function Questionnaire {Please Check any that apply}**

### **The “O” Group**

Do ANY of these apply to your present feelings?

- Your life seems incomplete.
- You feel shy with all but your close friends.
- You have feelings of insecurity.
- You often feel unequal to others.
- When things go right you sometimes feel undeserving.
- You feel something is missing in your life.
- You occasionally feel a low self worth or esteem.
- You feel inadequate as a person.
- You frequently feel fearful when there is nothing to fear.

### **The “G” Group**

Please note the items which apply to your present feelings.

- You often feel anxious for no reason.
- You sometimes feel “free floating” anxiety.
- You frequently feel “edgy” and find it difficult to relax.
- You often feel a “knot” in your stomach.
- Falling asleep is sometimes difficult.
- It’s hard to turn your mind off when you want to relax.
- You occasionally experience feelings of panic for no reason.
- You often use alcohol or other sedatives to calm down.

### **The “D” Group**

Please note the items which apply to your present feelings.

- You lack pleasure in life.
- You feel there are no real rewards in life.
- You have unexplained lack of concern for others, even loved ones.
- You experience decreased parental feelings.
- Life seems less “colorful” or “flavorful”
- Things that used to be “fun” aren’t any longer enjoyable.
- You have become a less spiritual or socially concerned person.

### **The “N” Group**

Please note the items which apply to your present feelings.

- You suffer from a lack of energy.
- You often find it difficult to “get going”.
- You suffer from decreased drive.
- You often start projects and then don’t finish them.
- You frequently feel a need to sleep or “hibernate”.
- You feel depressed a good deal of the time.
- You occasionally feel paranoid.
- Your survival seems threatened.
- You are bored a great deal of the time.

### **The “S” Group**

Please note the items which apply to your present feelings.

- It’s hard for you to go to sleep.
- You can’t stay asleep.
- You often find yourself irritable.
- You’re emotions often lack rationality.
- You occasionally experience unexplained tears.
- Noise bothers you more than it used to. It seems louder than normal.
- You “Flare Up” at others more easily than you used to.
- You experience unprovoked anger.
- You feel depressed much of the time.
- You find you are more susceptible to pain.
- You prefer to be left alone.

