

Fibromyalgia-Chronic Fatigue New Patient
Confidential Questionnaire

Fibromyalgia Solutions Center of the Triad

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Please briefly describe your health problems:

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--

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:

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

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. _____

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?

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.

