FCT® Patient Questionnaire

Please complete and bring to your appointment. If you need more space, continue on a blank page.
Your answers are confidential. The more open and helpful you are, the better we can help your health.

Date …… **Name** …… **Birth Date**……

Address: **Street**…… **Town**……

County…… **Postcode**…… **Country**……

Telephone: (1)……☐Home ☐Work **(2)** ……☐Home ☐Work

Email address…… **Occupation** ……

In case of emergency notify: (relationship) …… Phone #: ……

CHIEF COMPLAINT: Referred by:

DENTAL HISTORY: Current no. of dental amalgam fillings (these are silver- or black-colored): _____

How long since the first one was placed? _____ Total number that have been removed: _____

When removed? _____ Removed by (circle which): (a) a regular dentist or (b) a holistic mercury-free dentist?

Did your mother have amalgam fillings before your birth (circle which)? YES / NO / PROBABLY / NO IDEA

And did your father and/or grandparents (circle which)? YES / NO / PROBABLY / NO IDEA

No. of gold caps, root canals or other dental restorations (indicate which):

EMFs: Your home is a (circle which): House / Apartment? / Which apartment floor? ___ / How many floors? ___

How far is the nearest: Cell phone mast _____ / Electricity tower_____ / Electrical substation_____ ?

Describe the view from your bedroom window: _____

Do you use (circle which): Cordless phone / Wi-Fi / Electric: blanket, shaver , toothbrush / Protective devices / Magnets?

Are there fluorescent lights / striplights / long-life (mercury) lightbulbs in your (circle which): Home / Office ?

Do any adjacent neighbors have a cordless phone? YES / NO / NO IDEA

How many of these are in your home? TVs ____ Computers/laptops ____

Specifications of each: how many are LCD/LED? ___ vs. plain LCD? ___
Unsure? Write here all the screen names in full (e.g. "Panasonic TX-50A400B"):

_____

If using a laptop, do you use a corded external keyboard & mouse? YES / NO

Do you use any telephones (circle which): Held to ear / On speakerphone function?

	Average Hours of Use Per **Day**:
TV	
Computer or tablet	
Cell phone	
Landline phone	
In a motor vehicle	

Type of heating used in home:_____ Which room do power lines enter? _____

Devices in your bedroom (circle which): TV / Computer / Clock radio / Lamp / Cell phone / Other appliances:

LIST SYMPTOMS IN ORDER OF PRIORITY (worst first): **Rate 1→10: 1=hardly there / 10=extremely bad**

Symptom & Description:	**Known triggers / Worse (<) or better (>) for…**	**When started:**	**Rating:**

Amount/level of:	Very Low	Low	Medium	High	Excessive	Erratic
General energy						
Sleep						
General appetite						
General thirst						
Circulation/warmth/heat						
Daily exercise						

Exercise Routine _____

Energy is best: ☐ a.m. ☐ p.m. ☐ Night ☐ Between meals ☐ Just after meals ☐ When moving ☐ Or still

Energy is worst: ☐ a.m. ☐ p.m. ☐ Night ☐ Before meals ☐ Just after meals ☐ When moving ☐ Or still

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Mind & Emotions: Check if current: ☐ Mood swings ☐ Anger/frustration ☐ Grief/sadness ☐ Racing mind ☐ Worry ☐ Fear ☐ Brain fog ☐ Poor memory ☐ Poor concentration ☐ Difficulty communicating

Stress: Current stress level between 1 and 10 (*1 = very relaxed, 10 = very stressed*): ……..

Factors most contributing to your stress: ☐ Health ☐ Work ☐ Money ☐ Family ☐ Other

What best helps you deal with your stress?

Note: If you feel ready to be open in this area, the purpose of the following is to enable us to better assist your health.

Men & women (circle): Sexual impotence / lack of interest / genital discharge / swelling / testicular pain / other:

Women only: No. of children: ….. No. of miscarriages: ….. No. of abortions: ….. Length of time on the Pill: …….

Menses (circle): *late* / *early* / *regular* / *irregular* / *absent*. Length of period _____ Time between periods _____

The flow has been: *heavy* / *light* / *regular*. List any symptoms which are worse *before* / *during* (circle which):

☐ Infertility ☐ Pregnant now ☐ Planning pregnancy ☐ Difficult birth(s) → Details:

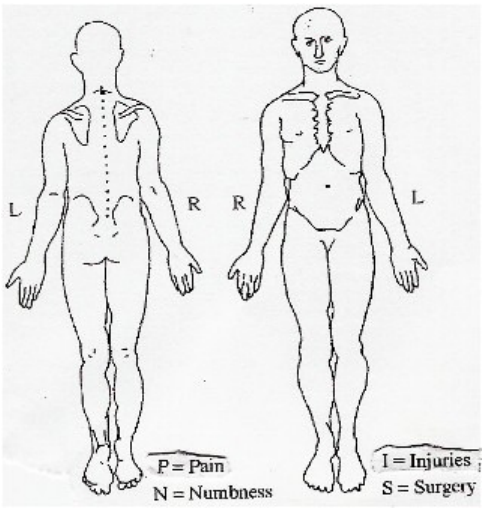
Systems Check – Circle any **current** problems, and **mark** any pain / numbness / surgery / injuries on the pictures:

Sleep – Probs. getting to sleep / Freq. waking / Early waking / Wake unrefreshed / Sleepiness / Night sweats

Infections – Recurring / Frequent / Colds / 'Flu / Sinusitis / Chest / Ear / Urethritis / Cystitis / Kidney / Stomach / Food poisoning / Poor immunity / General 'run down' feeling / Sinus congestion / Drip / Phlegm

Head – Headaches / Migraines / Seizures / Panic attacks / Poor hearing / Ringing / Blurred vision – distance / near / Visual Spots / Confusion

General – Nausea / Swelling/edema / Chronic fatigue / Easily tired



Lower back/kidney area – Pain/soreness

Chest – Difficulty breathing / Palpitations / Burning / Pain / Angina

Urination – Difficulty / Incontinence / Pain / Frequent night visits to toilet

Bowels – Indigestion / Heartburn / Abdominal pain / Bloating / Gas / Rectal itching / *How often do you pass stools?* ……..……..…..

Stools tend to be: Okay / Loose (L) / Constipated (C) / Alternating (L & C)

Nerves, Muscles & Joints – Burning / Numbness / Tingling / Sensitivity / Poor Mobility / Poor Co-ordination / Muscle Weakness / Recurring pain in: Back / Neck / Shoulder / _____

Skin & Hair – Eczema / Psoriasis / Rash / Itchiness / Dryness / Spots / Athlete's foot / Jock itch / Hair loss

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MEDICAL HISTORY:

TUBERCULOSIS	ARTHRITIS	MENSTRUAL DYSFUNCTION	DIZZINESS / FAINTING
SCARLET FEVER	KIDNEY DISEASE	DIABETES	CLAUDICATION
RHEUMATIC FEVER	LIVER DISEASE	THYROID DISEASE	HEART ATTACK
VENEREAL DISEASE	GASTRO-INTESTINAL DISORDER	FATIGUE	HEART MURMUR
EPILEPSY / SEIZURE DISORDER	GENITO-URINARY DISORDER	BRONCHITIS / EMPHYSEMA	CONGENITAL HEART DISEASE
MENTAL ILLNESS / DEPRESSION	SEXUAL DYSFUNCTION	ASTHMA	CONGESTIVE HEART FAILURE
CANCER	ANAEMIA	ALLERGIES / HAY FEVER	HIGH BLOOD PRESSURE
GOUT	HYPERLIPEDAEMIA	SHORTNESS OF BREATH	ARRHYTHMIA
ULCER	ANXIETY	ORTHOPNEA	STROKE / TIA'S

OTHER: _____

FAMILY HISTORY:

	Father	Mother	Father's Parents	Mother's Parents	Siblings
HEART DISEASE					
HIGH BLOOD PRESSURE					
STROKE					
TUBERCULOSIS					
CANCER					
GLAUCOMA					
DIABETES					
EPILEPSY					
BLEEDING DISORDER					
KIDNEY DISEASE					
THYROID DISEASE					
MENTAL ILLNESS					

Your known allergies/sensitivities:

Please circle: Many / Few / Don't know

Details:

TOXICITY (other): Do you smoke? YES / NO Have you ever smoked (actively or passively)? YES / NO

Packs daily _____ How long _____ When stopped _____

Have you used recreational drugs? YES / NO Which _____ How long _____ When stopped _____

Have you ever been exposed to industrial/chemical toxins at work or home? (e.g. factory/farming…) YES / NO

What chemicals/what industry/how long?_____ When stopped _____

Have you ever used weed killer or other agricultural chemicals? Y / N Do your neighbors? Y / N / NO IDEA

Do you use a coal stove/fire (either regular or 'smokeless' coal)? Y / N Do your neighbors? Y / N / NO IDEA

Do you live near any of the following (i.e. within about 1-2 miles, OR further if downwind) (circle which):

a nuclear plant / crematorium / industrial zone / polluting factory / golf course / agricultural area?

Have you ever been exposed to any other known major environmental toxins? Y / N / NO IDEA If yes, explain:

TRAVEL: Have you ever travelled to remote regions (eg: Asia/Africa/South America…) YES / NO

Date	Destination(s)	Health Incidents There or After?	Date	Destination(s)	Health Incidents There or After?

DIET:

How much do you eat/drink of the following:	None	Very Little	Moderate	Very Much
Vegetables	____	____	____	____
Beans/legumes, nuts, seeds	____	____	____	____
Meat, fish (Which?.....)	____	____	____	____
Chicken, turkey or eggs (not organic, even if free range)	____	____	____	____
Chicken, turkey or eggs (organic)	____	____	____	____
Dairy Foods (milk, cheese, yogurt, etc.)	____	____	____	____
White flour/starches: bread, pasta, potatoes, rice	____	____	____	____
Whole grains: wholewheat, oats, spelt, barley, rye	____	____	____	____
Candies (cakes, cookies, desserts, chocolate, sodas …)	____	____	____	____
Fruit and/or fruit juice	____	____	____	____

Average alcohol consumption per week: _____ ☐ History of alcohol addiction

Amount of water consumed daily (on its own): _____ Mark below the type(s) of water you drink:

Tap ____ Filtered Tap ____ Reverse Osmosis ____ Distilled ____

Energized ____ →*If so, energized how?* ____ Bottled ____ →*If so, which brand(s)?* _____

PAST TREATMENTS: Approx. no. of courses of **Antibiotics** received in your life: ☐0 ☐1-10 ☐11-20 ☐21+

For what? _____ When was last one received? _____

Approx. no. of **X-rays** received in your life: ☐0 ☐1-10 ☐11-20 ☐21+ When was last one received? _____

For what? (mammograms, injuries, dental, chest, etc…)_____

Approx. no. of **Vaccinations** received in your life: ☐0 ☐1-10 ☐11-20 ☐21+

Which ones? _____ When was last one received? _____

Briefly list your previous treatment / detoxification history (including conventional or alternative medicine):

WHEN BEGUN	WHEN ENDED	TREATMENT	WHEN BEGUN	WHEN ENDED	TREATMENT

HOSPITALIZATIONS / SURGERIES:

INCIDENT	DATE	INCIDENT	DATE

ACCIDENTS: Have you ever been knocked unconscious? Any blows to the head / spine / other injuries? Details:

CURRENT TREATMENTS:

List medications you currently use (prescribed or over-the-counter): [***BRING A SAMPLE OF EACH TO YOUR APPT***]

NAME	FREQUENCY	DOSAGE	SINCE WHEN	NAME	FREQUENCY	DOSAGE	SINCE WHEN

☐ Long-term medication(s) *past* / *present* (circle which). Details:

List all the supplements / homeopathics / herbs you are currently taking: [***BRING SAMPLES OF THESE TOO***]

NAME	FREQUENCY	DOSAGE	SINCE WHEN	NAME	FREQUENCY	DOSAGE	SINCE WHEN

Is any other practitioner providing treatments/therapies for you at the present time? YES / NO Details: