Dr. Brian Bailey Patient History Form

Please fill something in each box. It helps us to know a lot about you. Do not wait until your appointment to fill it out. Bring it in filled out completely.

First Name

Last Name

Age

Date of Birth

Day

Month

Year

Describe the stress from which you suffer

How long have you been dealing with stress?

What stands in the way of your dealing better with stress?

List any medications you take for stress (if you have a list from your pharmacy please add it separately)

With whom are you in conflict?

List any medications you take for other conditions

Have you ever been in therapy? If so, how did it go?

Consider this situation. You are in the passenger seat of your best friend's car. Your friend is excitedly telling you a story and not watching the road. The weather suddenly turns, with rain and snow coming down, and cars ahead are slipping around. What do you do?

Consider this situation. You have agreed to take some very young children camping. After a great day, you take them to a provincial park to camp out. They have settled down nicely when a car of teenagers drinking beer and playing loud music arrives next to you. What do you do?

List your 3 biggest weaknesses

1.

2.

3.

List your 3 biggest strengths

1.

2.

3.

Who suggested you come to AcuDestress?

Do you have a family doctor? Shall I send a report?

Have you been treated for mental health problems or substance addiction? How?

Ever been given a mental health diagnosis?

List any allergies

How well did treatment work? Be specific.

How many alcoholic drinks per week?

Any difficulties sleeping? If yes, be specific (if medications, which one(s)

GLUTEN SURVEY check off any of the following that apply to you:

Digestive	Hormonal	Neurological	Immune
Bloating/gas	Fatigue incl. CFS	Headache (migraine)	Joint aches/pains
Constipation and/or diarrhea	Anxiety and/or Depression	Memory Difficulties	Easily gets infections
Weight problems	Infertility	Brain fog	Cancer (you or family)
Iron deficiency anemia	Thyroid problems	Arthritis	Celiac Disease
Acid Reflux	Osteoporosis	Fibromyalgia	

Auto-immune Disease
You or family. Please name disease and family member (see list below)

If you or your family have suffered from **an autoimmune disease**, including any of the following, please list that condition above and state who in your family has this disease.

▪Addison's disease ▪Ankylosing spondylitis ▪Autoimmune chronic active hepatitis (CAH) ▪Autoimmune hemolytic anemia (AR) ▪Autoimmune thrombocytopenic purpura ▪Antiphospholipid Syndrome (APS) ▪Bullous pemphigoid ▪Celiac disease ▪Crohn's Disease ▪Cryo-globlulinemia ▪Dermatitis herpetiformis (DH) ▪Discoid lupus erythematosus ▪Encephalomyelitis ▪Giant Cell Arteritis ▪Graves Disease ▪Guillain Barré Syndrome ▪Primary Biliary Cirrhosis ▪Hashimoto's Thyroiditis ▪Inflammatory bowel disease ▪Insulin-dependent diabetes ▪Kawasaki disease (KD) ▪Systemic lupus erythematosis ▪Meniere's Disease ▪Multiple Sclerosis ▪Myasthenia Gravis ▪Oophoritis ▪Pernicious anemia ▪Polyarteritis nodosa (PAN) ▪Polymyalgia Rheumatica ▪Polymyositis/Dermatomyositis ▪Raynaud's phenomenon ▪Rheumatoid arthritis (RA) ▪Sarcoidosis ▪Sjogren's syndrome ▪Stiff-man/Stiff-person syndrome ▪Scleroderma ▪Wegener's granulomatosis

List any significant physical disease history in your past or present

List mental illness in your family, including suicide with member's relationship to you

List family non-mental i.e. physical illness history and whom it involved

Were you **born before full 9-month term?**

Born Caesarian section?

Many Respiratory infections as a child?

Learning disabilities as a child or adult?

DATE

Signature