PATIENT HISTORY FORM
for Dr. Brian C. Bailey M.D.

PLEASE FILL THIS FORM OUT IN ADVANCE OF YOUR INTAKE APPOINTMENT SO THAT THE DOCTOR CAN DISCUSS IT WITH YOU. IF POSSIBLE FILL IT OUT AT HOME BEFORE COMING.

YOUR FRST NAME:___________________

YOUR LAST NAME ___________________

YOUR AGE _____ Who suggested/referred you to AcuDestress? ________________________

Who is your doctor? Shall we send a report?

____

WHAT ARE THE SYMPTOMS OF THE STRESS FROM WHICH YOU SUFFER

HOW LONG HAVE YOU BEEN STRESSED?

HAVE YOU BEEN TREATED WITH MEDICATION? IF SO, WHICH MEDICATION(S)

WITH WHAT SUCCESS?

HAVE YOU EVER BEEN GIVEN A DIAGNOSIS RELATED TO STRESS? I F SO, WHAT ONE?

HAVE YOU BEEN TREATED WITH COUNSELLING OR PSYCHOTHERAPY? IF SO, WITH WHAT SUCCESS?

WHAT DO YOU THINK STANDS IN THE WAY OF YOUR DEALING WTH STRESS?

Consider this situation. You are the passenger in the front seat of a car driven by a very good friend, who is excited about something which has been occurring and wants to tell you about it. But you see that your friend doesn't see that the road ahead is dangerous, What do you do - if anything?

List your three biggest weaknesses

Consider this situation. You have agreed to take some very young kids camping. After a great day, you find a campsite at a provincial park and pitch a tent and put the children to bed. Just then a car of teenagers enters the next campsite, and are singing loudly and drinking beer. How do you respond?

List your three biggest strengths

HOW MANY ALCOHOLIC DRINKS DO YOU DRINK IN ONE WEEK?

HAVE YOU EVER BEEN TREATED FOR SUBSTANCE ADDICTION? and if so, did you succeed?

Yourself LIST ANY major physical diseases or injuries in your lifetime (use extra sheet if your list is extensive.) including medications you presently take for these problems.

Your Family
LIST ANY physical or MENTAL diseases which run in your family., including suicide, physical or sexual abuse. Specify who is/was affected…

Signature ______________
Date of your intake ___________

LIST ALL ALLERGIES

LIST ANY SLEEP PROBLEMS and ways you deal with them. medications?

GLUTEN SURVEY. Please **circle** any symptoms below which occur more than occasionally

bloating/gas	mood swings/ anxiety or depression	joint aches & pains
constipation/ diarrhea	osteoporosis	fibromyalgia
nausea	infertility	gets infections easily
weight problem	thyroid problems	arthritis you or family
iron deficiency anemia	headache (migraine)	cancer you or family
fatigue	memory difficulties	celiac disease you or family
sleep problems	brain fog	autoimmune disease you or family (see below)

The following are **autoimmune diseases**. If you see one which you or a family member have, circle it. **If you don't recognize these, simply omit doing this.**

alopecia areata • autoimmune hemolytic anemia • autoimmune hepatitis • dermatomyositis • diabetes (type 1) • some forms of juvenile idiopathic arthritis • glomerulonephritis • Graves' disease • Guillain-Barré syndrome •idiopathic thrombocytopenic purpura • myasthenia gravis • some forms of myocarditis •multiple sclerosis • pemphigus/pemphigoid • pernicious anemia polyarteritis nodosa • polymyositis • primary biliary cirrhosis • psoriasis •rheumatoid arthritis • scleroderma/systemic sclerosis • Sjögren's syndrome • systemic lupus erythematosus • some forms of thyroiditis (Hashimoto's) • some forms of uveitis • vitiligo • granulomatosis (Wegener's)