The Healthworks Clinic
Kevin Eakins, ND, Dip Hom, MHMA

CONFIDENTIAL

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.

Name: _____ Date:_____ Birth Date_____

Full Address: _____

_____

Post Code:_____ Country:_____

CONTACT NUMBERS

Home. : _____ Work:_____ Mob: _____

Email : _____ Occupation:_____

In Case of Emergency, notify: _____ (Relationship)_____

Tel: _____ Email (if any) _____

CHIEF COMPLAINT: _____ Referred By:_____

DENTAL HISTORY

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

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 storeys? ___

How far is the nearest: Mobile phone mast _____ / Electricity pylon_____ / High power generator _____ ?

Describe the view from your bedroom window: _____

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

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

Do any direct neighbours have a cordless phone? **YES / NO/ DON'T KNOW**

How many of these do you and residents have? TVs _____ Computers/laptops _____

Check specifications of each: how many are "LCD"? ___ vs. "LCD/LED"? ___

If unsure, write here all the TV and Computer screen brand names:

_____

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Do you use a laptop without an external keyboard and mouse? YES / NO

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

Type of heating used in home:_____ Which room do power lines enter (houses only)? _____

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

	Average Hours of Use Per **Day**
TV	
Computer or Tablet	
Mobile Phone	
Landline Phone	
In a Motor Vehicle	

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						

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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

Rate 1☐10: 1=hardly there / 10=extremely bad

MIND & EMOTIONS: Tick 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 /

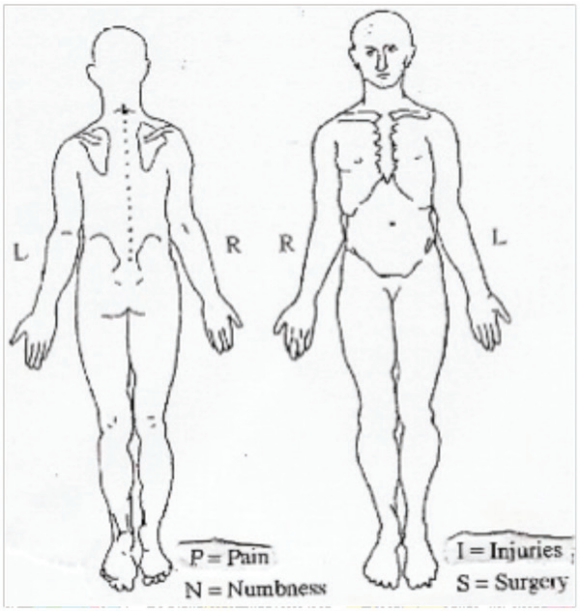
Head – Headaches / Migraines / Seizures / Panic attacks / / Poor hearing / Ringing / Blurred vision – distance / near / / Visual Spots / Confusion /

General – Nausea / Swelling/oedema / 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 /



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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 /

€ TCULOSIS	€ 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

MEDICAL HISTORY:

OTHER: _____

FAMILY HISTORY: (please tick box if anything in the table below is relevant to you)

	Father	Mother	Fathers Parents	Mothers 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:_____

_____

_____

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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? YES / NO Do your neighbours? YES / NO

Do you use a coal stove/fire (either regular or 'smokeless' coal)? YES / NO Do your neighbours? YES / NO

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? YES / NO

If yes, explain: _____

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

Date	Destination	Health Incidents. (There or After)	Date	Destination	Health Incidents. (There or After)

DIET:

How much do you eat/drink of the following:	None	Little	Moderate	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	____	____	____	____
Sweets (cakes, biscuits, puddings, chocolate, soft drinks…)	____	____	____	____
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 ____

Energised ____ How? _____ Bottled ____ ☐ If so, which brand(s)? _____

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

For what? _____ When was last one received? _____

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

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

Approx. no. of Vaccinations received in your life: ☐ 0-10 ☐ 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:

Ever 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 APT]**

NAME	FREQUENCY	DOSAGE	SINCE WHEN	NAME	FREQUENCY	DOSAGE	SINCE WHEN

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

_____

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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:_____

_____

_____

_____

_____

_____

_____