

# DR JAA'S MEDICAL HEALTH

## Pfeiffer Mental Health Questionnaire #2

The following survey will help us to gage an overall understanding of your physical and mental wellbeing. All information is kept in the strictest of confidence and part of our Medical Teams privacy policy.

NAME: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender:       Male -  Female

Contact Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

## About Yourself

Education (Last grade completed): \_\_\_\_\_

Significant Birth Events: \_\_\_\_\_

Injuries: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Pregnancies: \_\_\_\_\_

Do you have allergies to ragweed pollen or grasses? \_\_\_\_\_

Do you have any food or chemical sensitivities? \_\_\_\_\_

Please list any current medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any previous medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is your primary diagnosis? \_\_\_\_\_

---

---

What is the present treatment approach? \_\_\_\_\_

---

---

Please describe your diet: \_\_\_\_\_

---

---

What are some of your favourite foods? \_\_\_\_\_

---

---

Do you often get sleepy after a meal?                      Yes / No

Do you have any sleep problems? \_\_\_\_\_

---

---

Do you usually recall dreams? \_\_\_\_\_

---

---

Do you smoke cigarettes? No / Yes - How many per day? \_\_\_\_\_

Do you drink alcohol? No / Yes - how often? \_\_\_\_\_

Did you enjoy school? Yes / No

What were your typical grades in school?

- Mostly A's
- Mostly B's
- Mostly C's
- Mostly D's
- Mostly F's

What were your favourite subjects? \_\_\_\_\_

---

---

What subjects did you find the most difficult? \_\_\_\_\_

---

---

Please rate your tendency for anger:

- High
- Average
- Low

Please rate your tendency for anxiety:

- High
- Average
- Low

Please list any hobbies you have: \_\_\_\_\_

---

---

Please list any sports you participate in: \_\_\_\_\_

---

---

Do you experience depression?

- Often
- Sometimes
- Never

Please rate your pain threshold:

- High
- Average
- Low

Do you function well under stress?      Yes / No

Are you competitive at sports?

- Very
- Average
- No

Did you continue to grow taller after age 16?      Yes / No

Were you ever married?      Yes / No

Do you have any children? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Personality

Please tick any of the following:

- Poor stress control
- Poor short term memory
- Sensitivity to bright lights
- Sensitivity to loud noise
- Morning nausea
- Affinity for spicy or salty foods
- Tendency to delay or skip breakfast
- Tendency to be overweight
- Very dry skin
- Obsessive/Compulsive tendencies
- Pale skin, inability to tan
- Extreme mood swings
- High irritability and temper
- History of a reading disorder
- History of underachievement
- Severe inner tension
- Little or no dream recall
- Frequent infections
- Autoimmune disorders
- Premature graying of hair
- White spots on fingernails
- Abnormal or absent menstrual periods
- Ringing in the ears
- Poor muscle development

Please tick any of the following continued:

- History of perfectionism
- "Fruity" breath and/or body odour
- Stretch marks (striae) on the skin
- Spleen-area pain
- Severe depression
- Severe anxiety
- Fear of aeroplane travel, severe weather conditions etc.
- Very strong willed
- Obsessions with negative thoughts
- Joint pains
- Delayed puberty
- Poor wound healing
- Dark or mauve-coloured urine
- Psoriasis
- Abnormal EEG
- Tendency to stay up very late
- Delusional thoughts
- Auditory hallucinations
- Social isolation
- Enjoys spicy foods
- Dry eyes and mouth
- Artistic or musical ability

## Medical History

Primary symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Onset of condition: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treatment that were effective: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treatments that failed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any family members with similar symptoms? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Family History

Please tick any of the following that may apply to a relative of family member:

- Temper tantrums
- ADD/ADHD
- Cancer
- Panic disorder
- Anxiety disorder
- Dementia
- Asthma
- Ulcers
- Heart disease
- Stroke
- Bipolar disorder
- Kidney problems
- Depression
- Autism
- Psoriasis
- Diabetes
- Arthritis
- Schizophrenia

Thank you for completing this form.