FCT® Patient Questionnaire

Please complete and bring to your appointment. If you need more space, continue on a blank page.
Your answers are strictly 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 amalgams (i.e. any silver- or black-coloured fillings): _______

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

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

Did your mother have amalgam fillings before your birth? YES / NO / PROBABLY / NO IDEA

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

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

OTHER TOXICITY Qs: Approx. no. of courses of antibiotics received in your life: ☐0-10 ☐11-20 ☐21+

For what? ____ When was last one received? ________

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

Packs daily ___________ How long ____________ When stopped ____________

Are there fluorescent lights in your kitchen, home or office (circle which)?
[Either striplights or long-life bulbs] YES / NO

Do you have a TV or computer in your bedroom (circle which)? YES / NO

Electric appliances near bed (e.g. clock radio/lamp/phone)? YES / NO

	Average Hours Per Day:
TV use	
Computer use	
Mobile phone use	
Landline phone use	

Do you use any of the following (please circle): electric blanket / electric shaver / electric toothbrush / magnets?

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

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 (please circle): [*e.g. within a mile or two, although near/far in this case is very relative]
a mobile phone tower / high power generator / crematorium / industrial zone / polluting factory / nuclear plant ?

Have you ever been exposed to any other major environmental toxins? YES / NO If yes, explain:

(turn over =>)

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

Symptom: **Description:** **Known triggers:** **When started:** **Rating:**

<u>Systems Check</u> – Circle any **<u>current</u>** problems, and **<u>mark</u>** any pain / numbness / surgery / injuries on the pictures.

<u>Sleep</u> – Problems getting to sleep / Freq. waking / Early waking / Wake unrefreshed / Sleepy / Night sweats

<u>General</u> – General 'run down' feeling / Frequent colds/flu / Nausea / Swelling/oedema

<u>Head</u> – Headaches / Migraines / Panic attacks / Scalp

<u>Eyes</u> – Blurred vision / Itchiness / Spots *<u>Ears</u>* – Hearing / Infections

<u>Sinuses</u> – Sinusitis / Congestion / Drip / Phlegm

<u>Resp / Heart</u> – Breathing / Infections / Palpitations / Chest pain/angina

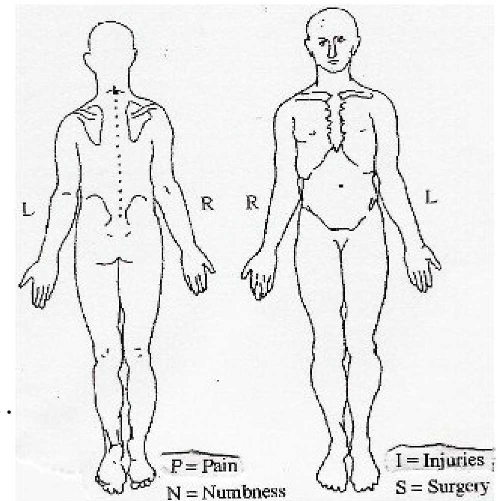
<u>Lower back/kidney area</u> – Pain/soreness *<u>Urination</u>* – Difficulty / Incontinence / Urethritis / Cystitis / Pain / Frequent night visits to toilet

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

<u>Stools tend to be</u>: Loose / Okay / Constipated / Alternating

<u>Nerves</u> – Pain / Burning / Numbness / Tingling / Sensitivity

<u>Muscle & Joints</u> – Pain / Inflammation / Recurrent back/neck/shoulder aches / Lack of mobility / Muscle weakness *<u>Skin</u>* – Eczema / Psoriasis / Rash / Itchiness / Dryness / Spots / Athlete's foot



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

Exercise Routine ____

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

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

(*turn to next page* =>)

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: Please circle: Sexual impotence/ lack of interest/ genital discharge/ testicular pain/ swelling/ other:

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

Menstruation has been: *late* / *early* / *regular* / *irregular* / *absent*. Length: of period _________ of cycle _________

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:

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					

Known allergies/sensitivities:

Please circle: Many / Few / Don't know

Details:

Vaccines you have received:

Which: When:

MEDICAL HISTORY

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

OTHER: ____

HOSPITALIZATIONS / SURGERIES:

INCIDENT	DATE	INCIDENT	DATE

ACCIDENTS: Ever knocked unconscious? Any blows to the head / spine / other injuries? Details:

(turn over =>)

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

NAME	FREQUENCY	DOSAGE	SINCE WHEN	NAME	FREQUENCY	DOSAGE	SINCE WHEN

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:

Briefly list your previous treatment / detoxification history:

WHEN BEGUN	WHEN ENDED	TREATMENT	WHEN BEGUN	WHEN ENDED	TREATMENT

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

☐ History of recreational drug use*. Details:

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	____	____	____	____
Sweets (cakes, biscuits, puddings, chocolates, sodas, etc.)	____	____	____	____
Fruit and/or fruit juice	____	____	____	____

Average units of alcohol per wk (*1unit = 1 glass of wine*): .... ☐ History of alcohol addiction*

[**N.B: The purpose of these questions is that FCT® may help remove residues and/or help with addictions.*]

Amount of water consumed daily (on its own): ______________ Check off below the type(s) of water you drink:

Tap ____ Filtered Tap ____ Reverse Osmosis ____ Distilled ____

Energised ____ Bottled ____ →*If so, which brand(s)?* ______________