



TOBIAS HEALING INSTITUTE

Felicitas Tobias-Ballesteros, M.D.

1140 Lake Street, Suite 204
Oak Park, IL 60301
Phone: (708) 848-1200
Fax: (708) 848-1201

Patient Information Health Appraisal Questionnaire

Date: _____ Referred By: _____

Patient Info

Last _____ First _____ M.I. _____
 Social Security #: _____ DOB: _____ Sex: Male Female

HEIGHT: _____ WEIGHT: _____ AGE: _____ OCCUPATION: _____

Home Address: _____
Street _____

City _____ State _____ Zip Code _____

Telephone: _____
Home _____ Work _____ Cell _____

E-Mail: _____

Employer Name: _____

Address: _____
Street _____

City _____ State _____ Zip Code _____

Emergency Contact: _____
Name _____ Phone _____ Relationship _____

Primary Insurance:

Insurance Name _____ Policy Holder's Name _____

ID Number	Group Number	Type	\$	\$
			Co-Pay	Deductible (Annual)

Relationship to insured Self Spouse Child Other _____

Policy Holder's Name (If other than self) _____
Last _____ First _____ M.I. _____

SSN _____ DOB _____

I hereby authorize and request payment to Tobias Healing Institute (THI) and/or Felicitas D. Tobias, M.D. for any medical/surgical benefits due under the terms of my insurance policy(s) for services rendered. I accept responsibility for payment of any insurance co-payments, deductibles, and any non-covered/non-insured services rendered.

Patient (or Guardian): _____
Signature _____ Date _____

HEALTH APPRAISAL INDICATOR

Use figures: (1) Mild (2) Moderate (3) Severe
Mark ALL that apply, leave the rest blank!

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal craving for sweets |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Afternoon headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol consumption |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies - tendency to asthma, hay fever, skin rash, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Awaken after few hours sleep - hard to get back to sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Aware of breathing heavily |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bad dreams |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Gums |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blurred Vision |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Brown spots or bronzing of skin |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily "black and blue" spots |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Butterfly" stomach, cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can't decide easily |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can't start in morning before coffee |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can't work under pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic nervous exhaustion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crave candy or coffee in afternoons |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cries easily for no reason |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depressed |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drinks ___ cups of coffee daily |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat often or get hunger pains or faintness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat when nervous |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Faintness if meals delayed |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue, eating relieves |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fearful |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Get "shaky" if hungry |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hallucinations |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hand tremor |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitates if meals missed or delayed |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Highly emotional |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hunger between meals |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inward trembling |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritable before meals |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lack energy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Magnifies insignificant events |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Moods of depression "blues" or melancholy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor memory |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Reduced initiative |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleepy after meals |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleepy during the day |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Weakness, dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Worrier, feel insecure |

← **Score**

CHIEF COMPLAINT

Answer with YES or NO to ALL that apply.

- | | | | | |
|--------------------------|---|--------------------------|---|------------------------------------|
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | A checkup |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Allergy (hay fever, hives, asthma) |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Annual Examination |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Back (spine and neck) |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Blood Pressure or stroke |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Brain or head |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Cancer |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Circulation |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Disease of the blood |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Dizziness or vertigo |

CHIEF COMPLAINT

Answer with YES or NO to ALL that apply.

- | | | | | |
|--------------------------|---|--------------------------|---|-----------------------------------|
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Ears |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Emotional problems |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Eyes |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Female Problems |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Fever |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Gal bladder, liver, jaundice |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Glands |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Growths (tumors) |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Headaches |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Heart |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Hernia (Rupture) |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Intestines and bowels |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Kidneys, urine, bladder |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Loss of weight |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Lungs and breathing |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Marital Problems |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Menopause (Change of life) |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Muscles or joints |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Nerves or nervousness |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Nose |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Other medical problems not listed |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Overweight |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Pain |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Pregnancy |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Problems with teeth and gums |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Sex Organs |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Sex problems |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Skin trouble |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Stomach and swelling |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Swollen glands |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Throat or mouth |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Tiredness- loss of pep or energy |
| <input type="checkbox"/> | Y | <input type="checkbox"/> | N | Underweight |

Other: _____

SOCIAL / PROFESSIONAL HISTORY

Marital Status: S M D W Other

Children? 1 2 3 4 5 n/a

Highest school level completed?

Grade Middle High
 College Graduate Trade

Occupation?

Unemployed Retired Student
 House Spouse Employed Disabled

What are your usual job duties or work?

<input type="checkbox"/> Domestic	<input type="checkbox"/> Chemical
<input type="checkbox"/> Clerical	<input type="checkbox"/> Health
<input type="checkbox"/> Professional	<input type="checkbox"/> Food Handler
<input type="checkbox"/> Trade	<input type="checkbox"/> Machinist
<input type="checkbox"/> Heavy	<input type="checkbox"/> Other

Were you ever in the U.S. Armed Forces?

Active Reserve National Guard

FAMILY MEDICAL HISTORY

The following applies to your blood relatives only!
Use figures: (G) Grandparent (M) Mother (F) Father
(S) Siblings (C) Child (R) other blood relative (N) N/A

- Have your blood relatives had the following:

- Borderline diabetes G M F S C R N
- Definite diabetes G M F S C R N
- Low blood sugar G M F S C R N
- Overweight G M F S C R N
- Goiter/enlarged thyroid G M F S C R N
- Overactive thyroid G M F S C R N
- Underactive thyroid G M F S C R N
- Malignancy/cancer G M F S C R N
- Epilepsy G M F S C R N
- Anemia G M F S C R N
- Birth Defects G M F S C R N
- High blood pressure G M F S C R N
- Heart Disease G M F S C R N
- Stroke G M F S C R N
- Kidney failure G M F S C R N
- Urine infection G M F S C R N
- Kidney stones G M F S C R N
- Gout G M F S C R N
- Arthritis G M F S C R N
- Other inherited diseases G M F S C R N

GENERAL INFORMATION

- Does your weight fluctuate? Y N
- Do you smoke? Y N
- Do you consume alcohol on a weekly basis? Y N
- Do you exercise regularly? Y N

GENERAL INFORMATION

- Have you had any accident? Y N
- Regarding your health, do you have any pending: Y N
 - Compensation claims Legal claims
 - Insurance claims
- Have you ever been rejected on a physical examination for:
 - Insurance Health card
 - Employment Blood donation
 - Military service
- Your current symptoms have occurred because of:
 - Work Lifestyle
 - Environment Heredity
 - I don't Know Other
- Are you exposed to:
 - Dust Lacquers
 - Fumes Varnishes
 - Chemicals / paints Excessive heat
 - Insecticides Excessive cold
- Have you ever been anemic? Y N
- Have you ever had cancer? Y N
- Are you a "bleeder"? Y N
- Are there "bleeders" in your family? Y N
- Have you ever received a blood transfusion? Y N
- Did you have any reaction to a transfusion? Y N
- Traveled outside the U.S. in the last two years? Y N
- If Yes, Where: _____
- If Yes...Did you become ill on any of these trips? Y N
- If Yes, What: _____

Complete this section to the best of your knowledge. Correct spelling is not required

- Any Serious Medical illness (Give dates & reasons)

- Hospitalizations and/or Surgery (Give dates & reasons)

- Your Current Medications...

- Additional Information you believe would be important
