

PFEIFFER MEDICAL CLINIC

Pfeiffer Questionnaire (Adult)

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| Y / N Seasonal Allergies | Y / N Vivid dreams or nightmares |
| Y / N Headaches | Y / N Many head colds |
| Y / N Seasonal depression | Y / N Fair complexion |
| Y / N Suicidal depression (ideas, gestures) | Y / N Upper body pain – neck, face, shoulders |
| Y / N Blankmindedness | Y / N Disordered thought |
| Y / N Increased reaction to pain | Y / N Racing thoughts |
| Y / N Compulsiveness | Y / N Paranoia (mild/strong) |
| Y / N Addictiveness | Y / N Hallucinations (seeing/hearing) |
| Y / N Rehash old memories | Y / N Dental cavities (few/many) |
| Y / N High sex drive | Y / N Many mood swings daily |
| Y / N Adult onset of symptoms | Y / N Low sex drive |
| Y / N Noncompliant with medication
(doesn't take them well) | Y / N Anxiety/Panic attacks |
| | Y / N Nervous tension |
| | Y / N Ringing in the ears |
| Y / N Sensitive to Light | Y / N Hyperactivity as child |
| Y / N Sensitive to sound | Y / N Continuous Depression |
| Y / N Sensitive to odors | |
| Y / N Stitch in side | |
| Y / N Decreased Short Term Memory | Y / N Weak Feeling |
| Y / N Prone to high Anxiety / Tension | Y / N Dizziness |
| Y / N Negativity or Pessimism | Y / N Fainting |
| Y / N Short or Explosive Temper | Y / N Blackouts |
| Y / N Does Not Recall Dreams | Y / N Craves Sweets |
| | Y / N Drowsy after Meals |

Patient Name: _____ Date: _____ DOB: _____