HEALTH QUESTIONNAIRE

Name: ____ D.O.B. ________________

Address: ____

City, State, Zip Code: ____

Phone: __________________________ Email:______________________________________

Occupation: _____________________________________ Hours you work per week: ________

Major Concerns(s), in order of significance to you:

1. ____

2. ____

3. ____

Foods in your typical diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Circle if you ingest regularly: coffee tea tobacco alcohol rec.drugs birth control pills tap water

Circle if you use regularly: conventional cleaning supplies lawn/household pesticides

conventional body products industrial chemicals

List your exercise activity and frequency:

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List your current medications, over the counter drugs and/or herbal supplements:

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Chronic health problems require a partnership between patient and practitioner. Please indicate how willing you are to change your:

DIET:	very willing	moderately willing	not likely
EXERCISE:	very willing	moderately willing	not likely
LIFESTYLE:	very willing	moderately willing	not likely
MINDSET:	very willing	moderately willing	not likely

How was your childhood health? Poor Fair Good Excellent

Please check the any of the following that you **have had** in the past or **currently** have:

- ❑ Low Energy
- ❑ Fatigue
- ❑ Brain Fog
- ❑ Pain
- ❑ Stiffness
- ❑ Numbness
- ❑ Tingling
- ❑ Joint Problems
- ❑ Muscular Problems
- ❑ Spasms, cramping, twitching
- ❑ Lingering old injuries
- ❑ Swelling anywhere in the body
- ❑ Allergies
- ❑ Sinus Problems
- ❑ Catch colds easily
- ❑ Poor vision, blurry vision, floaters
- ❑ Tonsilitis
- ❑ Strep Throat
- ❑ Ear, Nose, Throat Problems
- ❑ Ringing in the ears
- ❑ Skin Rashes
- ❑ Acne
- ❑ Digestive Problems
- ❑ Bloating, gas, reflux, nausea
- ❑ Low or excessive appetite
- ❑ Fatigue after eating
- ❑ Cravings
- ❑ Urinary Problems
- ❑ UTI's, kidney stones
- ❑ Respiratory Problems
- ❑ Asthma
- ❑ Headaches
- ❑ Chicken Pox
- ❑ Shingles
- ❑ Staph Infection
- ❑ Mononucleosis
- ❑ Bacterial Vaginosis
- ❑ Herpes
- ❑ Other bacterial or viral infections
- ❑ Blood sugar Problems
- ❑ Blood pressure problems- high or low
- ❑ High Cholesterol
- ❑ Abnormal Bowel Movements
- ❑ Poor Sleep
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Fear
- ❑ Worry
- ❑ Restlessness
- ❑ Dizziness
- ❑ Menstrual Difficulties
- ❑ PMS
- ❑ Hormonal Imbalance
- ❑ Hot Flashes or Night sweats
- ❑ Genital swelling, itching, heat?coldness
- ❑ Strong body odor, gas odor, breath
- ❑ Silver dental fillings in your mouth

How would you rate your daily stress level? LOW MEDIUM HIGH

Please describe what you do in your life that brings you joy: ______________________________

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