Health and Lifestyle Questionnaire

All information you provide in this questionnaire will be treated as private and confidential. It will only be released to other individuals with your written permission.

Name _____ Date of Birth _____ Age _____ Sex _____

Address _____ City/State/Zip _____

Phone _____ Fax _____ Email _____

Occupation / Employer _____ Church / Religion _____

Marital Status: □ single □ married □ divorced □ widowed

Spouse's name _____ Ages of children _____

What is the best time and method to get in touch with you? _____ □ phone □ email

What is your height _____ Weight _____ Desired weight _____

Current Health Concerns:

Please list your main health concerns or issues:

1.
2.
3.
4.

What active medical conditions are you currently receiving treatment for:

	Condition	Date started	Current Treatment
1.			
2.			
3.			
4.			
5.			

Allergies:

Medications: _____

Foods: _____

Environmental: _____

Medications you are currently taking (include hormones and non-prescription medicines)

Name_____ Dose_____ Times/Day_____

Name_____ Dose_____ Times/Day_____

Name_____ Dose_____ Times/Day_____

Name_____ Dose_____ Times/Day_____

Name_____ Dose_____ Times/Day_____

Name_____ Dose_____ Times/Day_____

Name_____ Dose_____ Times/Day_____

Supplements you are currently taking (use additional page if necessary):

Females only:

Are you currently, or could you be pregnant: Yes No
Are you currently menstruating: Yes No
Do you have breast implants: Yes No
Are you in Menopause: Yes No
Date of Last Menstrual period: _____
Date of last: Breast exam _____ PAP smear _____ Mammogram _____
Thermogram _____

Do you have issues or concerns with:			Describe:
- Hormone balance	□ Yes	□ No	
- Missed or irregular periods	□ Yes	□ No	
- Hot flashes	□ Yes	□ No	
- Premenstrual symptoms	□ Yes	□ No	
- Infertility	□ Yes	□ No	

Males and Females:

When was the approximate date that you most recently had the following?

- Complete physical exam _____
- Diagnostic blood tests _____
- Dental check-up _____
- Vision exam _____
- Hearing test _____
- EKG _____
- Exercise stress test (treadmill or other) _____
- Sigmoidoscopy or Colonoscopy _____
- Stool exam for blood _____
- Lung function tests _____
- Bone density scan _____

Were any of the above tests abnormal? Please describe:

Are you currently receiving other alternative or "natural" therapies?

□ chiropractic □ acupuncture □ therapeutic massage
□ homeopathy □ colonics □ chelation
□ kinesiology □ juicing □ herbal (specify _____)
□ other _____

Medical History: (Required for any Treatment Center therapies)

Please check any condition(s) that you or close family members have been diagnosed with, have a history of, or are currently experiencing:

Myself	Family Member (specify who)
☐ Abnormal Bleeding	☐ _____
☐ Addiction(s)	☐ _____
☐ Adrenal Fatigue	☐ _____
☐ Anxiety/Panic attack	☐ _____
☐ Arthritis	☐ _____
☐ Autoimmune Disease	☐ _____
☐ Blood Clots	☐ _____
☐ Bowel Disease	☐ _____
☐ Cancer	☐ _____
☐ Depression/Psychiatric Illness	☐ _____
☐ Diabetes	☐ _____
☐ Dizziness	☐ _____
☐ Epilepsy/Seizures	☐ _____
☐ Fatigue/Chronic Fatigue	☐ _____
☐ Fever	☐ _____
☐ Gout	☐ _____
☐ Headaches/Migraines	☐ _____
☐ Heart Disease	☐ _____
☐ Hepatitis	☐ _____
☐ High or Low Blood Pressure	☐ _____
☐ HIV / AIDS	☐ _____
☐ Kidney disease	☐ _____
☐ Kidney stone	☐ _____
☐ Liver disease	☐ _____
☐ Organ Transplant	☐ _____
☐ Phlebitis	☐ _____
☐ Respiratory/Lung Disease	☐ _____
☐ Skin condition	☐ _____
☐ Thyroid Disorder (hypo/hyper)	☐ _____

Other: _____ Other: _____

Please describe and provide dates:

Surgeries (include all cosmetic procedures and implanted medical devices):

_____

_____

_____

Accidents/Injuries: _____

_____

_____

Lifestyle and Nutrition:

Have you been exposed to potentially harmful chemicals, metals, or radiation at home or at work? (for example – dental fillings, pesticides, radioactivity, solvents)

Exposed to: When Exposed: How Exposed:

Smokers: Type smoked _____ Amount per day _____Age started ___ Age stopped ___

Alcohol consumption: Drinks/week _____ Typical beverages _____

Coffee: Cups/day _____ Diet Soda or other drinks with Aspartame/day _____

Recreational Drug Use _____

Exercise Summary: Are you currently involved in an exercise program? □ Yes □ No

Describe your current exercise _____

_____

Describe and limitations or problems you have with activity or exercise: _____

_____

Do you have exercise equipment at home? □ Yes □ No

Are you an active member of a health club or gym? □ Yes □ No

Are you presently receiving physical therapy? □ Yes □ No

If yes, describe:

What sort of exercise program would you prefer to do if there were no limitations? (describe)

Sleep History:

Number of hours you typically sleep each night _____

Do you usually sleep well and awaken refreshed? □ Yes □ No

Do you have trouble falling asleep? □ Yes □ No

Do you often wake during the night and have trouble falling asleep again? □ Yes □ No

Do you have a history of snoring or sleep apnea? □ Yes □ No

Do you get sleepy or take naps during the day? □ Yes □ No

Do you use sleeping medication or other aids to help fall asleep? □ Yes □ No

On a scale of 1 to 10, please rate the following areas in your life at the present time:

	Worst		Poor		OK		Pretty Good			Best
My energy level is:	1	2	3	4	5	6	7	8	9	10
My appetite is:	1	2	3	4	5	6	7	8	9	10
My diet is:	1	2	3	4	5	6	7	8	9	10
My sleep is:	1	2	3	4	5	6	7	8	9	10
My exercise is:	1	2	3	4	5	6	7	8	9	10
My symptoms are:	1	2	3	4	5	6	7	8	9	10
My attitude is:	1	2	3	4	5	6	7	8	9	10
My overall health is:	1	2	3	4	5	6	7	8	9	10

Nutrition Summary:

Describe any specific philosophy or approach you have to nutrition and diet:

What special diets have you tried in the past? What results?

What foods do you consistently overeat?

Do you crave
- sugar and sweets ☐ Yes ☐ No
- breads and pasta ☐ Yes ☐ No
- chocolate ☐ Yes ☐ No
- salty foods ☐ Yes ☐ No
- fatty foods ☐ Yes ☐ No
- other _____

Describe your nutrition on a **typical "good day"** (please list a menu of food you eat)

Breakfast Time: _____

Meal: _____

_____

Morning Snack Time: _____

Meal: _____

_____

Lunch Time: _____

Meal: _____

_____

Afternoon Snack Time: _____

Meal: _____

_____

Supper Time: _____

Meal: _____

_____

Evening Snack Time: _____

Meal: _____

_____

Describe your nutrition on a **typical "bad day"**

Breakfast Time: _____

Meal: _____

_____

Morning Snack Time: _____

Meal: _____

_____

Lunch Time: _____

Meal: _____

_____

Afternoon Snack Time: _____

Meal: _____

_____

Supper Time: _____

Meal: _____

_____

Evening Snack Time: _____

Meal: _____

_____

Who is your primary health care provider? _____Specialty? _____

Their office phone number: _____ Do you give permission for our physicians to discuss your medical situation with your primary health care provider? Yes _____ No _____

Your signature _____ Date _____

MEDICAL SYMPTOMS QUESTIONNAIRE

Patient Name _____ Date _____

Rate each of the following symptoms based on your typical health profile for the past 30 days.

Point scale: 0 = never or almost never have the symptom
1 = occasionally have it, effect is not severe
2 = occasionally have it, effect is severe
3 = frequently have it, effect is not severe
4 = frequently have it, effect is severe

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia Total _____

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened, or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(does not include near- or far-sightedness) Total _____

EARS
_____ Itchy ears
_____ Earaches, Ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss Total _____

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucous formation Total _____

MOUTH / THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gum, lips
_____ Canker or cold sores Total _____

SKIN
_____ Acne
_____ Hives, rashes
_____ Dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating Total _____

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain or pressure Total _____

LUNGS
_____ Chest congestion
_____ Asthma, wheezing, bronchitis
_____ Shortness of breath
_____ Difficulty breathing Total _____

DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn, indigestion	
	_____	Intestinal, stomach pain	Total _____
JOINTS / MUSCLES	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of muscle weakness	Total _____
GENITOURINARY	_____	Frequent or urgent urination	
	_____	Having to get out of bed to urinate at night	
	_____	Difficulty starting or stopping urine stream	
	_____	Urinary incontinence	
	_____	Genital itch, discharge, or sores	
	_____	Vaginal yeast infections (women)	Total _____
WEIGHT	_____	Binge eating / drinking	
	_____	Craving certain foods	
	_____	Excessive weight, inability to lose weight	
	_____	Compulsive eating	
	_____	Water retention	
	_____	Underweight, inability to gain weight	Total _____
ENERGY / ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	Total _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Poor concentration	
	_____	Poor physical coordination	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	Total _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	
	_____	Lack of sex drive, decreased libido	
	_____	Suicidal thinking or behavior	Total _____
OTHER	_____	Frequent illness, slow recovery from illness	
	_____	Fever, chills, or night sweats	
	_____	Cold hands or feet	
	_____	Burning, numbness, tingling in hands or feet	
	_____	Excessive thirst	
	_____	Sleep problems, insomnia	
	_____	Food intolerances, food allergies	Total _____

OVERALL TOTAL _____