Health Questionnaire

Name _____ Gender _____ Date _____

Age _____ Age I feel _____ Weight _____ Optimum Weight _____

Last time that I felt really good _____

Anything happening before I started to feel bad?_____

(new medications, change in medications, physical trauma, emotional trauma etc.)

Main Symptom: _____

How long have you had it? _____

What makes it better? _____

What makes it worse? _____

Anything about your symptoms that don't make sense: _____

Any other symptoms associated with it or started at same time? _____

_____

Hereditary History (circle)	**You**	**Father** Father's Family	**Mother** Mother's Family	**Children**	**Sibling**
Neurological (Depression/ADHD/Memory/Anxiety)	Y	F	M	C	S
Digestion(Constipation/Diarrhea/Bloating/Heartburn)	Y	F	M	C	S
Heart Disease/Stroke/Blood Pressure	Y	F	M	C	S
Endocrine (Thyroid/adrenals/reproductive)	Y	F	M	C	S
Arthritis (Osteo/Rheumatoid/Gouty)	Y	F	M	C	S
Sugar (Hypoglycemia/Diabetes)	Y	F	M	C	S
Insomnia (Hard to get to sleep/stay asleep)	Y	F	M	C	S
Autoimmune (Lupus/Diabetes/Thyroid/Rheum)	Y	F	M	C	S
Cancer	Y	F	M	C	S

Anything else that you think is important for me to know??? _____

_____

List of Medications (prescription and non-prescription)

Name	Purpose of Medication	Life sustaining?
1. _____	_____	❑ YES ❑ NO
2. _____	_____	❑ YES ❑ NO
3. _____	_____	❑ YES ❑ NO
4. _____	_____	❑ YES ❑ NO
5. _____	_____	❑ YES ❑ NO
6. _____	_____	❑ YES ❑ NO
7. _____	_____	❑ YES ❑ NO
8. _____	_____	❑ YES ❑ NO

Diet

1. How would you rate your diet for health (1-10) 10 being best _____
2. How many meals a day do you eat a day? _____
3. How many glasses of water do you drink a day? _____
4. How many times a week to you eat fast foods? _____
5. What percentage of foods that you eat are organic ? _____
6. Do you try to avoid refined foods, trans fats, artificial flavorings? _____
7. Are you addicted to sugar or caffeine? _____

Lifestyle

1. Exercise Type _____ How often? _____ Duration_____

2. Meditation? _____ How Often? _____

3. Yoga? _____ How Often?_____