

CONFIDENTIAL HEALTH & LIFESTYLE QUESTIONNAIRE

Name _____ Date _____

Address _____ Postal code _____

Home Phone # _____ Cell # _____

Office # _____ ext. _____

Occupation: _____

Date of Birth (M) ____ (D) ____ (Y) ____ Age ____

Marital Status _____ Name of Spouse _____

Dependants: _____

Height _____ Present Weight _____ Normal Weight _____

When were you last this weight? _____

How did you hear of this office? _____

Name of Family Medical Doctor _____

Name of Chiropractor _____

Name of Massage Therapist _____

What is your blood type? (Circle one) A B AB O Don't know

What is your chief concern about your health?

Who diagnosed your illness? _____

When was this diagnosis made? _____

What specialists have you seen? (Year of Consultation) _____

How has this illness been treated? _____

What else would you like to see changed in your health? (How long has each existed)

1. _____

2. _____

3. _____

4. _____

 5. _____

 6. _____

 7. _____

 8. _____

How long has it been since you were totally well? _____

Previous History:

- | | | |
|--|--|--|
| Measles <input type="checkbox"/> | Low Blood Pressure <input type="checkbox"/> | Croup <input type="checkbox"/> |
| Ear Infection <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Eczema <input type="checkbox"/> |
| Cold sore <input type="checkbox"/> | Epilepsy <input type="checkbox"/> | Diarrhea <input type="checkbox"/> |
| Mumps <input type="checkbox"/> | Hay Fever <input type="checkbox"/> | Chicken Pox <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Stroke <input type="checkbox"/> | Psoriasis <input type="checkbox"/> |
| Chlamydia <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Genital Herpes <input type="checkbox"/> |
| Scarlet Fever <input type="checkbox"/> | Frequent <input type="checkbox"/> | Migraines <input type="checkbox"/> |
| Abscesses <input type="checkbox"/> | Colds/Flus <input type="checkbox"/> | Parasites/Worms <input type="checkbox"/> |
| Gonorrhea <input type="checkbox"/> | Gallstones <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| Rheumatic Fever <input type="checkbox"/> | Anemia <input type="checkbox"/> | Rheumatism <input type="checkbox"/> |
| Warts <input type="checkbox"/> | Allergies <input type="checkbox"/> | Hepatitis <input type="checkbox"/> |
| Venereal Warts <input type="checkbox"/> | Kidney Stones <input type="checkbox"/> | Asthma <input type="checkbox"/> |
| Diphtheria <input type="checkbox"/> | Hypoglycemia <input type="checkbox"/> | Alcoholism <input type="checkbox"/> |
| Depression <input type="checkbox"/> | Swollen Glands <input type="checkbox"/> | Pleurisy <input type="checkbox"/> |
| HIV <input type="checkbox"/> | Mononucleosis <input type="checkbox"/> | Shigella <input type="checkbox"/> |
| Hemorrhoids <input type="checkbox"/> | Frequent Headaches <input type="checkbox"/> | |
| Malaria <input type="checkbox"/> | Sinusitis <input type="checkbox"/> | |
| Arthritis <input type="checkbox"/> | Whooping Cough <input type="checkbox"/> | |
| Candida <input type="checkbox"/> | Panic Attacks <input type="checkbox"/> | |
| Pneumonia <input type="checkbox"/> | Bowel Disease <input type="checkbox"/> | |
| Gout <input type="checkbox"/> | Constipation <input type="checkbox"/> | |
| Sexual Abuse <input type="checkbox"/> | | |

Any other conditions? _____

Were any of the above severe? If so, give age, severity and duration

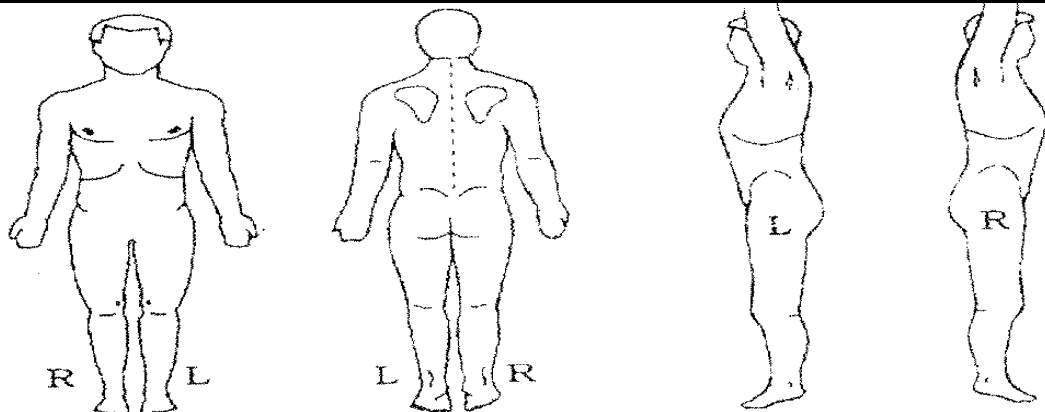
Describe your general state of health as a child

Describe your general state of health as a teenager

Please indicate any surgeries you have had, when and where they were performed?

Please indicate any accidents you have had. What injuries were sustained, when they occurred and what treatment was required

Were there any complications associated with the above?



Medications:

List all prescribed medications presently you are taking. Indicate the drug name, dosage, frequency and how long you have taken it

List all prescribed medication you have taken in the past for a period longer than three months

List any prescribed medication you have had a bad reaction to in the past. Indicate the drug name, when you took it, and the reaction you had

Have you ever had a severe reaction from a vaccination?

Yes No

(If yes, explain the vaccination type, when it was administered and the following reaction)

How many courses of antibiotics have you had in the past ten years?

Have you ever had a bad reaction to an antibiotic? Yes No

List any over-the-counter medications you take. (i.e. Aspirin, tums, Tylenol)

Family History:

Please indicate the AGE of all relatives living and indicate the age at which any family member became deceased. (L=Living, D=Deceased)

Father: L____ D____ Mother: L____ D____
 Brothers: L____ D____ Sisters: L____ D____
 L____ D____ L____ D____

Indicate if there have been any of the following diseases in your grandparents, parents, brothers or sisters. Indicate the number of relatives who have/had the following diseases.

Diabetes ____	Multiple Sclerosis ____	Drug Abuse ____
Hypertension ____	Mental Illness ____	Arthritis ____
Gastro-intestinal ____	Rheumatism ____	Asthma ____
Cancer ____	Depression ____	Alcoholism ____
Allergies ____	Alzheimer Disease ____	Epilepsy ____
Stroke ____	Kidney Disease ____	Other ____
Heart Disease ____	Tuberculosis ____	
Goiter ____		

Additional History: -----(IF MALE)

Have you ever had any of the following? Check all that apply:

Hernias Testicular Masses
 Prostate Sexual Difficulties
 Disease None of the above
 Urination Difficulties

Additional History:----- (IF FEMALE)

Age of first Menses: ____ Age of cessation of menses ____
 Are your menses: Regular Irregular
 Date of last menstrual cycle _____
 Do you experience PMS: Yes No

If yes, what do you experience?

Have you experienced fibrocystic disease of the breast?

Yes No

Have you had uterine fibroids? Yes No

Do you have recurring vaginal infections?

Never Rarely Frequently More than 3 times a year

How often do you experience a cystitis (bladder infection)?

Never Rarely Frequently More than 3 times a year

Marital Status

Single Married Divorced # of Years _____

Number of children _____ Ages _____

Number of pregnancies _____ Deliveries _____

Number of miscarriages _____ Abortions _____

Diet & Lifestyle:

How many cups/bottles/glasses do you drink on the average per day?

Water _____ Wine _____ Soft Drinks (Diet) _____

Fruit Juice _____ Tea _____ Milk – Skim _____

Beer _____ Herbal Tea _____ Soft Drinks Reg.) _____

Coffee _____ Liquor _____

Vegetable Juice _____ Milk 2% _____

Check if you use the following:

Artificial Sweetener

Distilled Water

Margarine

Luncheon Meats

Check if you do the following:

Eat fast foods often

Eat a lot of sweets

Salt food before tasting

List all the food supplements you are presently taking. Indicate the total dosage taken on one day. (If you take 2 tablets of VIT "C"500mg, total daily is 1000mg)

Do you presently smoke? Yes No How many cigarettes____ Cigars____

Have you ever smoked? Yes No How Long _____

When did you quit _____

Does anyone else smoke in your household? Yes No

Does anyone in your workplace smoke? Yes No

How often would you have an alcoholic Beverage?

Do you presently use or have you ever used recreational drugs? Y N

(If yes, indicate the type and frequency of usage).

How many hours of sleep do you get on the average? _____

Do you have any problem falling or staying asleep? Yes No

Do you awaken feeling rested? Yes No

How many hours do you work each day? _____

Are you satisfied in your career/work? Yes No

Are you exposed to any chemicals at work? Yes No

What type?

What do you do for exercise? (Indicate type, how often you participate, and the length of each occasion).

When was your last vacation? _____

What do you do for recreation? _____

What level of personal stress are you experiencing right now?
Minimal Average Considerable Unbearable

Areas of Stress:

Interpersonal Marriage
Family Members Financial
Job Related Spiritual
Health Unfulfilled Expectations
Other _____

Do you participate in any spiritual discipline or belong to a church or religious group? Are you an active participant?

Thank you for taking the time to fill out the requested information. It will help greatly in our study of your present health and will assist us in choosing an appropriate direction to take in working toward your desired restoration of health.