

Health Questionnaire for _____ Date: _____

List the five (5) Main Complaints, in order of importance:
1.
2.
3.
4.
5.

List Current & Past Medications and their purpose:

List Over-The-Counter Medications

List of Allergies or Sensitivities:

List of Vitamins taken:	List of Herbs taken:	List of Homoeopathics taken:

Health Questionnaire for _____ Date: _____

Describe Your General Health: Good Fair Poor

Sleep _____ hrs/night Do you sleep on your Back Side Stomach

Exercise _____ hrs/week Is your bed comfortable? No Yes What kind of bed? _____

What kind of pillow do you use? Thick Medium Thin None Support Water-filled Other

Do you wear...? Heel lifts Shoe lifts Arch Supports Orthotics Other _____

CONDITIONS: Check (☑) conditions you have or have had in the past.			
<input type="checkbox"/> AIDS	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Measles	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Fractures	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tumors, growths
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hernia	<input type="checkbox"/> Polio	<input type="checkbox"/> Vaginal infections
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Cataracts	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Other
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatoid arthritis	

Have you had the following exams?	Date	Result
Mammogram		
Bone Density		
Pap Smear		
Thermography		
Blood Tests		
Colonoscopy		
Sigmoidoscopy		
Biopsies		
Dental Exam		
Physical Exam		

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Blood Pressure		
Cholesterol		
Prostate Exam		
Other:		

Place of Birth: _____ Raised?: _____

Have you traveled outside the USA, where? _____ when? _____

How much of the following do you consume now or in the past:

Alcohol: _____ / week

Tobacco: _____ / day

Caffeine: _____ / week

If you were born between 1945 – 1975 did your mother take diethylstilbestrol (DES) or other drugs to prevent miscarriages during her pregnancy with you? _____

List Surgeries you have had...

EXERCISE and Your Health:

What is your current weight: _____ Height: _____

What is the body weight you currently feel is the best for you?: _____

Have you been on diets in the past to lose or gain weight?: _____

How do you feel about your body fitness presently?: _____

Type of Aerobic exercise: _____

How many times a week?: _____

Do you stretch?: _____ How long?: _____

Do you Weight Train? _____ How many times a week?: _____

Have you ever worked with a trainer?: _____ How many sessions?: _____

Are you satisfied with your exercise program?: _____

Do you need some kind of support with your exercise program?: _____

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EMOTIONAL Health:

Do you feel connected in your life with family and friends?: _____
 Do you feel connected spiritually (however you define that)?: _____
 Do you regularly get out in nature?: _____
 In general, do you see the cup as half full or half empty?: _____
 What do you do to reduce stress?: _____
 Do you feel that you are depressed or anxious?: _____
 Have you ever received counseling?: _____
 If you have a primary relationship, do you feel good about your relationship?: _____
 How long have you been together?: _____
 Are other stress factors affecting your life? Financial, relationships, work, living-space _____

How would you describe your energy level throughout the day?					
	High	Low	Tired	Best	Comments
Morning					
Afternoon					
Evening					

Neck, Back , Extremities Check <input checked="" type="checkbox"/> symptoms you currently have or have had in the past year.			
NECK	MID-BACK	ARMS & HANDS	LEGS & FEET
<input type="checkbox"/> Pain in neck	<input type="checkbox"/> Mid-back pain	<input type="checkbox"/> Pain in upper arm R L	<input type="checkbox"/> Pain down leg R L
<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Mid-back stiffness	<input type="checkbox"/> Pain in elbow R L	<input type="checkbox"/> Pain in knee R L
<input type="checkbox"/> Neck weakness	<input type="checkbox"/> Pain between shoulder blades	<input type="checkbox"/> Pain in forearm R L	<input type="checkbox"/> Pain in ankle R L
<input type="checkbox"/> Pinched nerve in neck	<input type="checkbox"/> Pain from front to back	<input type="checkbox"/> Pain in hand R L	<input type="checkbox"/> Pain in foot R L
<input type="checkbox"/> Neck feels out of place	<input type="checkbox"/> Muscle spasms	<input type="checkbox"/> Pain in fingers R L	<input type="checkbox"/> Weakness in leg R L
<input type="checkbox"/> Muscle spasms in neck	LOW BACK	<input type="checkbox"/> Pins/needles in arm R L	<input type="checkbox"/> Weakness in knee R L
<input type="checkbox"/> Grinding/popping in neck	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Pins/needles in fingers R L	<input type="checkbox"/> Weakness in foot R L
SHOULDERS	<input type="checkbox"/> Low back stiffness	<input type="checkbox"/> Numbness in arm R L	<input type="checkbox"/> Leg Cramps R L
<input type="checkbox"/> Pain in Shoulder joint R L	<input type="checkbox"/> Low back weakness	<input type="checkbox"/> Numbness in fingers R L	<input type="checkbox"/> Foot Cramps R L
<input type="checkbox"/> Pain across shoulders	<input type="checkbox"/> Pinched nerve-low back	<input type="checkbox"/> Weakness in arm R L	<input type="checkbox"/> Tingling in foot R L
<input type="checkbox"/> Can't Raise arms R L	<input type="checkbox"/> Low back out of place	<input type="checkbox"/> Weakness of hand R L	HIPS
<input type="checkbox"/> Can't raise arm above shoulder R L	<input type="checkbox"/> Muscle spasm-low back	<input type="checkbox"/> Coldness in hand R L	<input type="checkbox"/> Pain in buttocks R L
<input type="checkbox"/> Can't raise over head R L	<input type="checkbox"/> Tingling	<input type="checkbox"/> Other	<input type="checkbox"/> Pain in hip joint R L
<input type="checkbox"/> Tension in shoulders	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Pinched nv. in shoulder R L	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other