Health questionnaire

Answering the questions as thoroughly as possible will provide important insight into your current health and help inform your treatment plan.

Date: **Name:**

Age: **Birth date:**

Address:

Mobile: **Landline:**

Weight: **Weight 1 year ago:** **Weight 5 years ago:**

Height: **Occupation:**

Employment: ☐ Full time ☐ Part time

Living situation (tick all that apply):

☐ Alone ☐ Friends ☐ Partner
☐ Spouse ☐ Parents ☐ Children
☐ Pets

Reason for visit

What are your major health concerns and intentions for your visit?

Please list any other health care providers or consultants you are currently working with (extra space on back page):

Current herbs, vitamins & dietary supplements (extra space on back page)

Product (inc. brand name if possible)	Dosage	Frequency (per day)

Current medications (extra space on back page)

Include aspirin, antacids, and all OTC (over the counter) products. Indicate OTC or P (prescribed).

Product	OTC or P?	Dosage	Frequency (per day)

Known allergies (extra space on back page)

List all medications, herbs, etc. to which you have a known allergy:

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Dietary information

Describe below your typical meals. Please be as specific as possible. For example, instead of "oil" list type of oil, such as olive, corn, etc. Instead of ''bread" list whether white or whole grain, etc. Instead of "vegetables" list the type of vegetable, how prepared, tinned, frozen, or fresh, etc. Please include all drinks, type and quantity (two cups of coffee, one glass of orange juice, etc.)

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Daily water consumption (glasses/day):

Any recurring food cravings (salt, starch, sugar, chocolate, etc.):

Food allergies / sensitivities (extra space on back page):

Food	Describe reaction

Family history

Please describe any relevant or major health-related issues (alcoholism, high blood pressure, cancer, diabetes, heart disease, psychiatric illness, osteoporosis, other addictions, other illnesses):

Mother:

Father:

Sister(s):

Brother(s):

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Other family members / recurring family health trends:

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Past health problems

List all major health problems including any operations (extra space on back page):

Problem	Year

General Health

Please tick any of the following that apply:

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain in heart
- ☐ Poor circulation
- ☐ Swelling
- ☐ Stroke / murmur

Skin
- ☐ Boils
- ☐ Bruises
- ☐ Dryness
- ☐ Itching
- ☐ Varicose veins
- ☐ Skin eruptions

Muscles / Joints
- ☐ Backache
- ☐ Broken bones
- ☐ Mobility problems
- ☐ Arthritis
- ☐ Bursitis
- ☐ Weakness

Respiratory
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Cough
- ☐ Tuberculosis
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma
- ☐ Coughing up blood

Urinary / Kidney
- ☐ Excessive urination
- ☐ Water retention
- ☐ Burning urine
- ☐ Kidney stones
- ☐ Lower back pain
- ☐ Dark circles under eyes
- ☐ Itchy ears / eyes
- ☐ Blood in urine

Gastro-Intestinal
- ☐ Belching
- ☐ Colitis
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Liver problems
- ☐ Gall stones
- ☐ Ulcers
- ☐ Transit time issues

Eyes, Ears, Nose & Throat
- ☐ Failing vision
- ☐ Sinus congestion
- ☐ Hearing loss
- ☐ Ear aches
- ☐ Hay fever
- ☐ Sore throat
- ☐ Sinus infection
- ☐ Tonsils
- ☐ Canker sores
- ☐ Nose bleeds
- ☐ Eye pains

General
- ☐ Fatigue
- ☐ Night sweats
- ☐ Fever
- ☐ Excessive thirst
- ☐ Loss of appetite
- ☐ Always hungry
- ☐ Difficulty sleeping
- ☐ Frequently colder or warmer than others

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Reproductive health

Male

☐ Burning / discharge ☐ Lumps / swelling of testicles ☐ Painful testicles

☐ Vasectomy

Female

Age of first period: ___ Regular: ☐ Yes ☐ No Length of cycle: ___

☐ Heavy bleeding ☐ Clots ☐ Colour/ amount

☐ Vaginal discharge ☐ Vaginal itching ☐ Pains / cramps

☐ Cervical dysplasia ☐ Pelvic pain ☐ Painful intercourse

☐ Breast lump ☐ Anaemia ☐ Breast pain

☐ Genital herpes ☐ Hot flushes ☐ Infertility

☐ Dry vaginal lining ☐ Osteoporosis ☐ Mood swings

Contraceptive / pregnancy history

Contraception used (tick all that apply):

☐ Birth control pills ☐ Rhythm method ☐ IUD/ coil

☐ Diaphragm ☐ Condoms ☐ Mucous method

☐ Cervical cap ☐ Spermicides ☐ Fertility lens

Please list each pregnancy (including miscarriages and abortions):

Pregnancy	Year	Notes

Current state of emotions & spiritual well-being

Please take time to consider and answer each of the following questions:

Are you completely satisfied with your living conditions?

Are you able to express your feelings and emotions?

Is there an excess of stress in your life? **What is causing the stress?**

Are you satisfied with your job?

If in a relationship, are you satisfied with it? **Are you lonely?**

Is there something you would like to change in your life? **Can you change it?**

Are you a "nervous type" of person? **What type of things make you nervous?**

Do you sleep well? **How many hours per 24-hour period?**

Do you dream? **Do you remember your dreams?**

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Are you satisfied with your energy levels? **Do you often feel exhausted?**

Is it easy to wake up in the morning?

Do you enjoy your work?

Do you have hobbies / activities you enjoy outside of work?

Which of these feelings dominate your life? (circle or tick)

☐ Joy ☐ Happiness ☐ Anger

☐ Sadness ☐ Fear ☐ Sympathy

☐ Worry ☐ Depression ☐ Other: _____

Do you believe in a higher power? **Are you at peace with this belief / relationship?**

Please list approximate dates and describe the nature of any traumatic experiences in the past 7 years (divorce, loss of loved one, loss of job, change of residence, injury, etc.):

Year	Event

Lifestyle habits

Type of exercise:	**Duration (minutes):**	**Frequency:**

Tobacco use: **How much?** **Previously?**

Alcohol: **How much?** **How often?**

Caffeine: **How much?** **How often?**

Mood altering substances (such as cocaine, marijhuana etc.): **How much?** **How often?**

How many hours of television do you watch in a week?:

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Additional information/ extra space

Please use this space to add any other information about yourself that you think will be helpful: