true nature
HEALTH CLINIC

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._____
_____

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4._____

_____

5._____

_____

6._____

_____

7._____

_____

8._____

_____

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

Previous History:

Measles ☐
Ear Infection ☐
Cold sore ☐
Mumps ☐
Cancer ☐
Chlamydia ☐
Scarlet Fever ☐
Abscesses ☐
Gonorrhea ☐
Rheumatic Fever ☐
Warts ☐
Venereal Warts ☐
Diphtheria ☐
Depression ☐
HIV ☐
Hemorroids ☐
Malaria ☐
Arthritis ☐
Candida ☐
Pneumonia ☐
Gout ☐
Sexual Abuse ☐

Low Blood Pressure ☐
High Blood Pressure ☐
Epilepsy ☐
Hay Fever ☐
Stroke ☐
Diabetes ☐
Frequent ☐
Colds/Flus ☐
Gallstones ☐
Anemia ☐
Allergies ☐
Kidney Stones ☐
Hypoglycemia ☐
Swollen Glands ☐
Mononucleosis ☐
Frequent Headaches ☐
Sinusitis ☐
Whooping Cough ☐
Panic Attacks ☐
Bowel Disease ☐
Constipation ☐

Croup ☐
Eczema ☐
Diarrhea ☐
Chicken Pox ☐
Psoriasis ☐
Genital Herpes ☐
Migraines ☐
Parasites/Worms ☐
Tuberculosis ☐
Rheumatism ☐
Hepatitis ☐
Asthma ☐
Alcoholism ☐
Pleurisy ☐
Shigella ☐

Any other conditions?_____

_____

_____

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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

_____

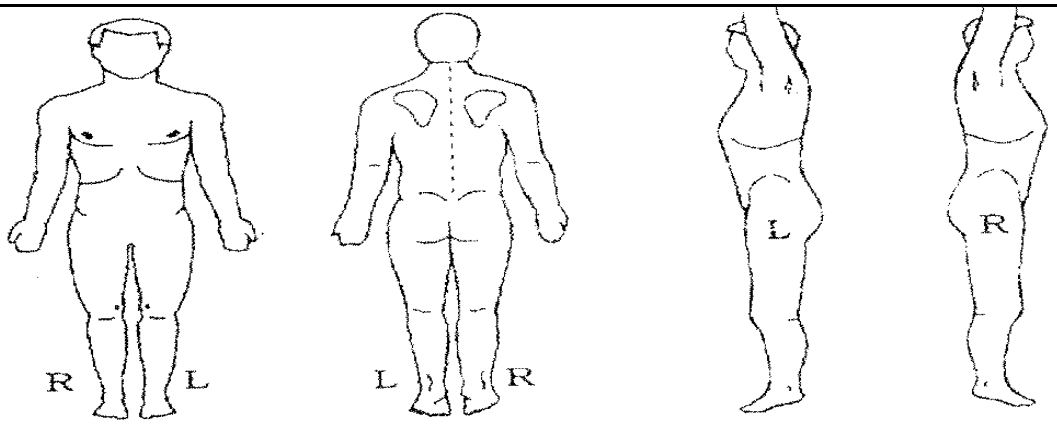
_____

_____

Were there any complications associated with the above?

_____

_____



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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)

_____
_____
_____
_____

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

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

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

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

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 ☐

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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 ☐

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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? _____

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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.

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