INTEGRATIVE™
HEALTH & WELLNESS
CENTER

HEALTH QUESTIONAIRE

Personal Information

Full name _____ Name you wish to be called _____

Street Address_____

City _____ State _____ Zip _____

Phone: H) _____ W) _____ E-Mail: _____

Date of birth _____/_____/_____ Age: _____ Gender: M / F Insurance Company: _____

Occupation: _____Employer: _____

Who were you referred by? _____

Person to contact in case of emergency _____ Phone _____

Primary Concern

What brings you to our clinic?

_____

_____

_____

_____

Date of original condition: _____ Date of most recent occurrence: _____

Was there an event that created the condition?

_____

Have you had this or similar conditions in the past? _____

What makes it better? _____ Worse? _____

Is the condition getting worse? _____Constant? _____

Worse at a certain time of day? _____

Is this condition interfering with: Work? _____ Sleep? _____ Activity? _____Other? _____

Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being.

_____
_____
_____

Health History

List other current health issues & problems:

_____
_____
_____
_____

List other practitioners seen, treatments, self-care activities, and results:

_____
_____
_____
_____

List illness you have had not previously mentioned, if any:

_____
_____

List all surgeries you have had, with dates and results:

_____
_____
_____
_____

Have you ever been in an accident or seriously injured? (if so, please describe)

_____
_____
_____

Do you have any dental or TMJ problems? Y N (if so, please describe)

_____
_____

Medication	Dosage	For Which Condition?	How long have you been taking this?

Have you had your wisdom teeth or other teeth removed? Y N *Have you ever had a root canal? Y N (if yes note which teeth) _____

List all vitamins, herbs and other supplements you are now taking, the dose, and reason for taking: _____
_____
_____

List all medications and other substances (i.e.: foods) to which you are allergic:
_____
_____

Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother_____

Children_____ Grandparents _____

Brothers _____ Sisters_____

General

*Describe your use of: Cigarettes/Tobacco _____Alcohol _____
Other drugs_____

*Describe your present exercise habits including frequency per week, duration, and heart rate:
_____
_____

* How many hours per night do you sleep? _____ * Do you fall right asleep? Y N

* Do you wake up feeling refreshed? Y N * Do you sleep through the night without awaking? Y N * Do you remember your dreams? Y N

* Do you snore? Y N *Do you have night-sweats? Y N * Do you have nightmares? Y N * Do you grind your teeth at night (bruxism)? Y N * Do you have restless legs (RLS)? Y N *When did you last receive the following (leave blank if it does not apply to you), (please remember to bring copies).

*Cholesterol or other blood tests _____
*Pap smear(women) _____ *Mammogram/Thermography (women)_____
* Prostate (men)_____* Other_____

Physical Activity

*Type of sport/activity/exercise routine you participate in:

*Hours you train/exercise average per week: _____

*Do you train by yourself or with others? (circle)

*Do you use a heart rate monitor? Y N *What type of shoes do you wear? (Name/Style)

* Do you wear orthotics/arch supports/or any other devices during the day or when you exercise?

*Have you progressed, regressed, or plateaued in the past year? (circle)

*How many injuries (minor included) or illnesses do you suffer from per year? _____

*If applicable: When & what is your next competition you hope to participate in, or which one do you wish to "peak" for?

_____

_____

Pain Questionnaire

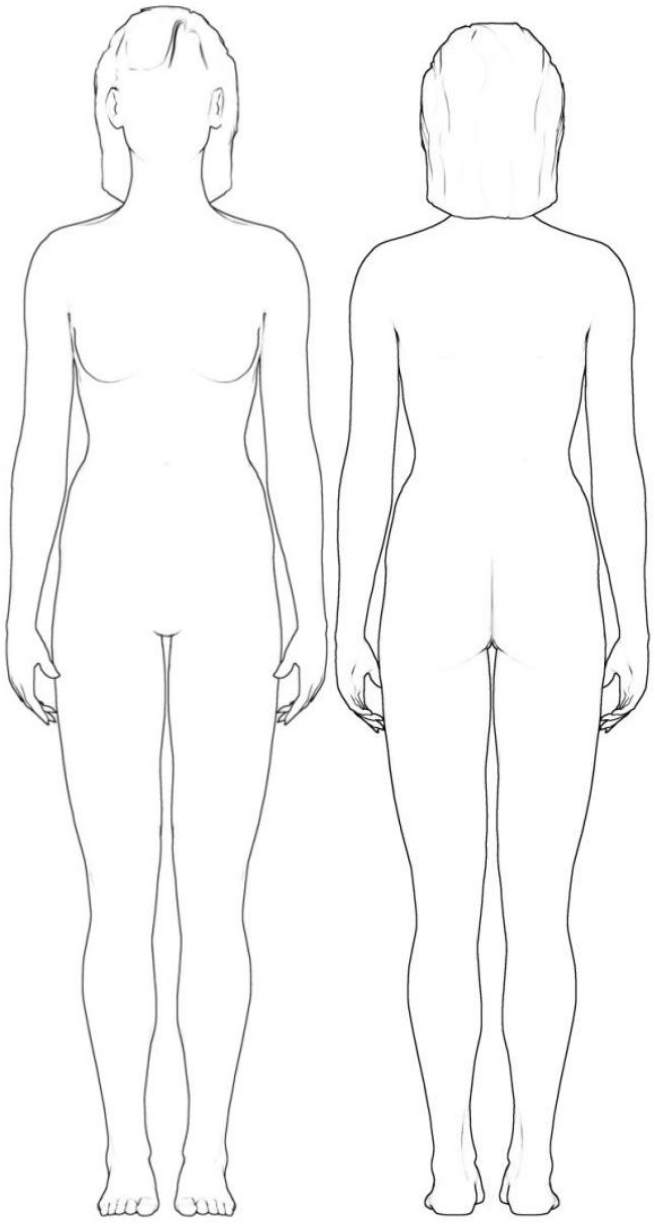
(Skip to the next section if you are not currently experiencing pain.)

Please place a single vertical line through the scale below at the point that best describes your pain. (0 is no pain, 10 is the worst pain imaginable)

0.....I.....I.....I.....I.....I.....I.....I.....I.....I.....10

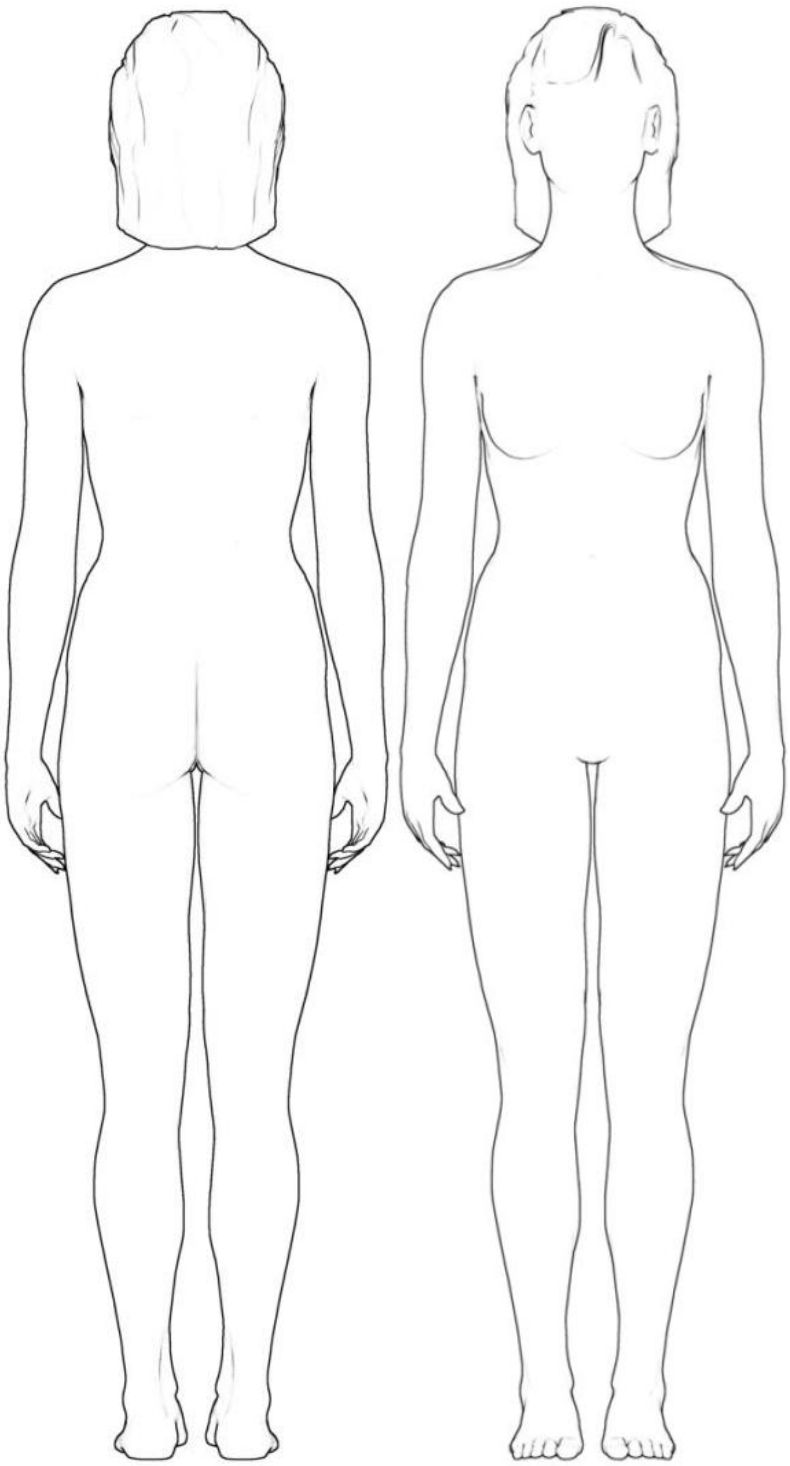
Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

A = Ache B = Burning N = Numbness O = Other P = Pins & Needles S = Stabbing T = Throbbing



History of Injury

Please mark with an "X" **all the places on your body which have ever been injured** (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.



Diet History

How much do you drink each day **(8oz)**: Water: _____ Juice: _____ Soda Diet: _____

Soda Regular: _____ Coffee: Regular: _____ Decaf: _____ Tea: Regular: ___ Tea Sweet: _____

Energy Drinks/Other: _____

List oils or fats that you use in cooking:
_____

Do you frequently skip meals? Y N

Are you on any special diet or nutrition program? Y N Describe:
_____

Are you allergic or sensitive to any foods? Y N If yes, name the foods and describe the problem.
_____

Circle the foods you crave: Meats, Fats, Sweets, Salty, Foods, Vegetables, Fruits, Breads, Spicy Foods, Sour Foods, Cereals, Dairy, Other: _____

*Do you eat from fast food restaurants? Y N -- If yes, how often? _____

What do you usually eat for **breakfast**? _____

What do you usually eat for **lunch**? _____

What do you usually eat for **dinner**? _____

What do you usually eat for **snacks** (in between meals and/or before bed)?
_____

What foods do you eat a lot of (at least once a day, every day)?
_____

How many bowel movements do you have per day? _____

Name(print): _____

Sign: _____ Date: _____