Questionnaire

Date:___________

Name:_______________________________ Date of birth:____________ Age: ________

Address:_____________________________ City:____________________State/Zip_____

Contact Telephone:_________________E-mail:___________________________________

Occupation:____

□ Fulltime □ Part time □ Unemployed □ Self-employed □ At home

Employer ______________________

Sex: F M Height:_____________Weight:________3 years ago_________

Living situation: □ Alone □ Partner □ Spouse □ Friends □ Parents □ Children □ Pets

Current diagnosis/symptoms:

____

____

____

Family Doctor: ____ Tel: ________________

Last physical exam:____

Medical History: list all surgeries &dates:

____

____

____

Known allergies:

____

____

What treatments have you attempted previously (conventional/alternative)?

____

____

Currently taking – Medications:

____

____

Currently taking - Supplements:

____

____

How much water do you typically drink in one day?____________________(glasses)

Do you drink - □ tap water □ bottled water □ purified water?

How many hours per week do you work out?__________

What type of exercise do you like?____

How many hours do you watch TV in a week? _____________________________

Favorite recreational activities:____

Are you on any special diet? ____

How many hours of sleep do you get each night?_________Do you wake up rested?____

Level of stress : 1-10 (10 = highest)________

Coffee _____________cups/day

Do you smoke? □ YES □ NO

Alcohol_____________drinks/ week

Recreational drugs? □ YES □ NO