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: _____

Occupation: _____Employer: _____

Who were you referred by? _____

Person to contact in case of emergency _____ Phone _____

Primary Concern

Please list your top five heath concerns:

_____

_____

_____

_____

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:

_____ -continued:

_____

_____

_____

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)

_____

_____

_____

*Have you ever had a root canal? Y N (if yes note which teeth) _____

Please fill out the “Current Medication Form” below:

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

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_____

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? _____

Pain Questionnaire

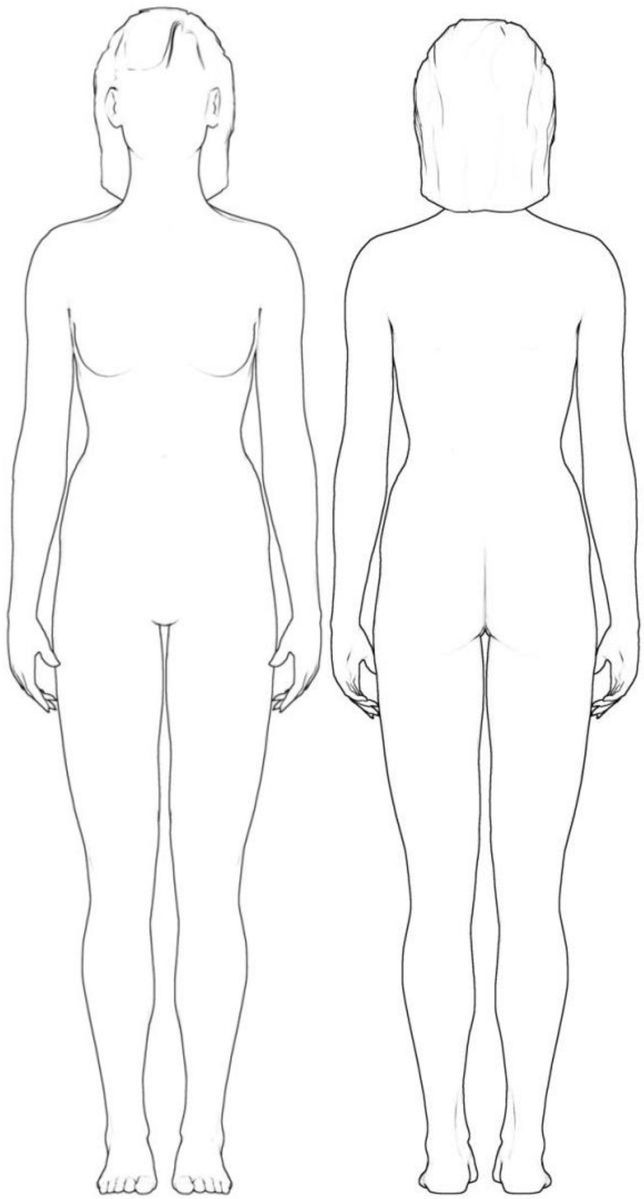
(Skip to the next section if you are not currently experiencing pain.)

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.........|.........|.........|.........|.........|.........|.........|.........|.........|.........10

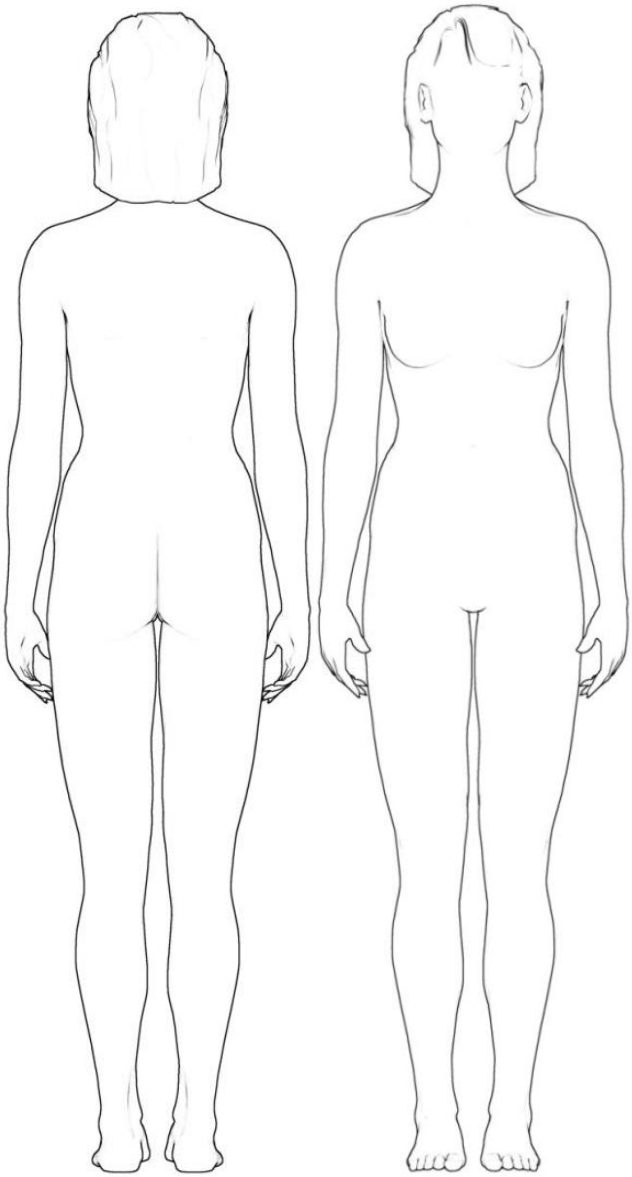
Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

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.



Please print sign and date below:

Name(print):_____

Sign:_____ Date:_____