

# HEALTH QUESTIONNAIRE

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

1. Do you currently take a multi-vitamin? \_\_\_\_\_ Yes \_\_\_\_\_ No
2. Do you know your blood type \_\_\_A \_\_\_AB \_\_\_ B \_\_\_O \_\_\_?

Do you take any supplements? *(please check all that apply)*

<input type="checkbox"/> Vitamin C	<input type="checkbox"/> B-Complex	<input type="checkbox"/> CoEnzyme Q10	<input type="checkbox"/> Magnesium
<input type="checkbox"/> Vitamin D	<input type="checkbox"/> Glucosamine	<input type="checkbox"/> Beta Carotene	<input type="checkbox"/> Chromium
<input type="checkbox"/> Vitamin E	<input type="checkbox"/> Garlic	<input type="checkbox"/> Calcium	<input type="checkbox"/> DHEA
<input type="checkbox"/> L-Carnitine	<input type="checkbox"/> Ginkgo Biloba	<input type="checkbox"/> Saw Palmetto	<input type="checkbox"/> Fiber
<input type="checkbox"/> Melatonin	<input type="checkbox"/> Flax Oil	<input type="checkbox"/> Fish Oil	<input type="checkbox"/> Other

3. Do you take any prescription drugs?  
If so, please list: \_\_\_\_\_

4. Are you allergic to any medications, foods, or environmental factors that you know of?

5. Which areas of health is a concern to you? *(check all that apply, circle your most pressing issue)*

<u>General Conditions</u> <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Back Pain <input type="checkbox"/> Bladder Dysfunction <input type="checkbox"/> Anxiety / Stress / Depression <input type="checkbox"/> Low Energy / Fibromyalgia <input type="checkbox"/> Ear / Hearing Problems <input type="checkbox"/> Kidney Problems or Stones <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Skin Conditions <input type="checkbox"/> Thyroid <input type="checkbox"/> Weight Control <input type="checkbox"/> Memory Loss <input type="checkbox"/> Hormones <input type="checkbox"/> Autoimmune	<u>Heart Disease</u> <input type="checkbox"/> Angina <input type="checkbox"/> Cholesterol <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> High Blood Pressure  <u>Digestion</u> <input type="checkbox"/> Constipation <input type="checkbox"/> Gas <input type="checkbox"/> Heartburn / Indigestion <input type="checkbox"/> Ulcers  <u>Vision Care</u> <input type="checkbox"/> Cataracts <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Glaucoma	<u>Women's Health</u> <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Hormone Replacement <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Menopause <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Heavy/Irregular Periods <u>Men's Health</u> <input type="checkbox"/> Prostate <input type="checkbox"/> Impotence  <u>Degenerative Diseases</u> <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____
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6. Who else lives in your home? *(please check all that apply)*

No Others     
  Spouse / Significant Other     
  Children

7. Have you recently painted or remodeled? \_\_\_\_\_ Yes \_\_\_\_\_ No

8. Water System Well, \_\_\_ City \_\_\_ or other what kind? \_\_\_\_\_

9. Do you have pets? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what kind? \_\_\_\_\_

10. Are you in a house that was built within \_\_\_\_\_ 1-5 yrs \_\_\_\_\_ 6-15 yrs \_\_\_\_\_ 16-25 yrs

11. What type of flooring is in your home? \_\_\_\_\_ Synthetic \_\_\_\_\_ Natural \_\_\_\_\_ How old

12. Do you use lawn chemicals? \_\_\_\_\_ Yes \_\_\_\_\_ No