

HEALTH & LIFESTYLE QUESTIONNAIRE

Today's Date: _____
Name: _____
M F Birthdate ___/___/___ Age _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____
Height: _____ Weight: _____ Marital Status: S M D W No. of children: _____
Daytime phone: (____) _____
Evening phone: (____) _____

1. Complaints: Please rank your current complaints and rate their severity (on a scale of 1 to 10, 10 being the most severe):

2. Other Information: Please tell us any additional information or concerns about your health:

3. Medications and/or Supplements: Please list any medications/supplements you are currently taking and how long you have taken them (including birth control pills, aspirin, pain medications, Vit C, Multivitamin, etc.)

4. Smoking: Do you currently smoke? _____ If yes, how much? _____ How long have you smoked? _____

5. Surgeries: What surgeries, operations, traumas, car accidents, etc. have you had?

a.) Have you ever had full-body anesthesia (i.e. to remove tonsils, wisdom teeth, etc.)? _____

b.) Do you have breast implants? _____
Other surgical implants or prostheses? _____

c.) Have you had elective surgery (*tummy tuck, face-lift, burned off moles, liposuction, etc.*)? _____

d.) Do you have any metal or plastic inside your body (*such as pins, clamps, plates, etc.*)? _____

e.) Do you have pierced ears or other body piercings? _____
Tatoos? _____

6. Scars: Describe any scars on your body (major and minor ones): _____

7. Drugs: This is strictly confidential information. Do you currently use recreational drugs? _____ [circle] (marijuana, cocaine, heroin, uppers, downers)

Others: _____ How often? _____

Have you used recreational drugs in the past? _____ If yes, for how long? _____

8. Stress: Please rate your current stress level (on a scale of 1 to 10, 10 being the highest stress): _____

What is the main reason(s) for your stress? _____

If over level 5, what step(s) are you taking to reduce your stress level? _____

9. Dental work: Indicate how many of the following you have:

Silver fillings _____ Gold crowns or inlays _____

Root canals _____ Braces _____

Composites (*tooth-colored*) _____ Stainless steel crowns or inlays _____

Root canals with BioCalex _____ Bleeding Gums _____

Extractions _____ Porcelain crowns or inlays _____

Posts _____ Sensitive teeth _____

Bridgework _____ DeGussa Porcelain crowns or inlays _____

Implants _____ Bad Bite _____

Partial or full dentures _____ Veneers _____

Temporaries _____ New cavities _____

Have you had any teeth extracted (wisdom teeth, four bicuspid extraction etc.)? _____

Have you had dental surgery (gum surgery, jaw surgery, etc.)? _____
Do you need further dental work? ____ If so, what? _____

Health Overview (For the following questions, circle the phrases that apply to you.)

1. Sleep: How is your sleep? [**Circle:** *restful, restless, hard to get to sleep, wake up often, get up during the night, bad dreams.*]
Other complaints? _____

What time do you usually go to sleep? _____ Number of hours of sleep per night? _____

2. Digestion: How is your digestion? [**Circle:** *adequate, poor, acid reflux, burp often, bloating, burning/pain in stomach.*]
Other complaints? _____

3. Urination: How are your daily urinations? [**Circle:** *every 2 to 3 hours, too frequent, sense of urgency, too small amount, too large amount, burning, dribbling, up at night several times.*]
Other complaints? _____

4. Bowels: How are your bowel eliminations? [**How often?** *3 times daily, once per day, skip days* **Amount:** *normal, too little, too large* **Consistency:** *normal, too hard, very soft, diarrhea* **Color:** *brown, black, whitish* **Other:** *lots of mucus, lots of gas, foul smell*]
Other complaints? _____

5. Women Only: Are you pregnant? ____ Are you breast-feeding? ____ Do you have monthly periods? ____ Date of last menstrual period? ____ Are you going through menopause? ____ Have your periods stopped? ____ Had a hysterectomy? ____ (If so, when? _____)

Menstrual Cycle: Are your monthly periods regular (28 day cycles)? ____ Number of days of your menstrual flow? ____ (Circle any of the following symptoms you experience associated with your period: cramping, bloating, feeling weak, mood swings, cravings, heavy bleeding, back

pain, headaches, bright red blood, dark clotty blood.)
Other menstrual complaints? _____

6. Exercise: What kind of exercise do you do? _____
How often? _____ For how long at a time? _____

7. Sunlight: Amount of natural sunlight you receive daily outside? _____ Amount of sunlight you receive daily through windows? _____ Hours spent daily under fluorescent lights? _____ Do you use Chromalux light bulbs at home? ____ At work? _____

8. Eyewear: Do you wear contact lenses? ____ Glasses? ____ If so, how many hours per day? ____ Do your lenses have tints? ____ An anti-glare coating? ____ A scratch-resistant coating? ____

9. Electromagnetic Exposure: How many hours do you spend daily:
Watching TV? ____ Working on a computer? ____ Talking on a phone? ____ Talking on a cellular phone? ____ Wearing a pager? ____ Wearing a headset? ____ Wearing a wrist-watch (with battery)? ____ Wearing a hearing aid? ____ Riding in a car/truck/vehicle? ____ Near electrical equipment for long periods of time (such as copy machines, high power lines, computers, etc.)? ____ When you sleep, is your head within 10 feet of a plug-in clock (such as on a nite stand)? ____

10. Clothing: How often do you wear 100% natural clothing (*cotton, ramie, wool, silk, or linen*)? _____ Synthetic clothing (*polyester, acrylic, nylon, rayon, etc.*)? ____ Blends (*natural fabric combined with synthetic*)? _____

11. Personal Care Products List the brand names that you use: (Please take time to complete this list.)

Shampoo? _____ Shave Cream? _____
Deodorant? _____ Dish Washing Liquid/Powder? _____

Toothpaste? _____ Laundry Soap? _____
Soap? _____ Tub/Tile Cleaner? _____
Hand/Body Lotion? _____ Glass Cleaner? _____

Facial Cleanser/Moisturizer? _____ All Purpose Cleaner? _____ Hair Spray/Gel? _____ Perfume/Cologne? _____

Personal (sexual) Lubricant? _____ Roach/Ant Spray? _____

Contraceptive jelly/spermicide? _____ Toilet Freshener? _____

Hair Dye? _____ Hair Permanent? _____ Fingernail/Toenail Polish? _____ Face make-up/ Eye make-up? _____ Other chemical exposure (from yard, workplace, art chemicals, etc.)? _____

12. Appliances Circle which of the following you use:

Gas stove Electric stove Electric heater Electric blanket Water bed Turbo Blend Microwave Oven Air Purifier (Brand: _____) Water Purifier (Brand: _____)

13. Cookware What type of cookware do you use? [Circle: stainless steel, aluminum, iron, teflon-coated, glass, Ultrex] Other types: _____

14. Shower Filter What brand of shower filter do you use (for chlorine protection)? _____ When was your filter last changed? _____

15. Pets Do you have a pet(s)? _____ If so, what kind/how many? _____ Is it allowed in the house? _____ On your bed? _____ What do you feed your pet(s)? _____

Food Choices: Circle each type of food that you eat often (once a week or more):

1. Pre-made foods: a) canned food b) boxed cereals c) frozen dinners d) bottled or frozen juices e) take-out food

2. Red meat (beef, pork, lamb): a) commercially grown b) naturally raised (Brand: _____)

3. Chicken: a) commercially grown b) naturally raised (Brand: _____)

4. Turkey: a) commercially grown b) naturally raised (Brand: _____)

5. Fish: a) canned tuna b) fresh fish c) frozen fish d) at restaurants

6. Fresh vegetables: a) commercially grown (store-bought) b) organically grown (store-bought) c) organically grown (direct from farmers)

d) from natural growers at a farmer's market

7. Fresh fruit: a) commercially grown (store-bought) c) organically grown (store-bought) c) organically grown (direct from farmer) d) from natural growers at a farmer's market

8. Whole grains: a) commercially grown (store-bought) b) organic (store-bought) c) organic (direct from farmer)

9. Whole beans: a) commercially grown (store-bought) b) organic (store-bought) c) organic (direct from farmer)

10. Eggs/ Butter: a) commercial eggs (store-bought) b) organic eggs c) commercial butter d) organic butter

11. Milk: a) commercial milk b) organic pasteurized milk c) organic goat's milk d) good quality raw whole milk (such as Claravale)

12. Cheese: a) commercial cheese b) organic aged cheese (store-bought) c) aged cheeses

13. Other: A) commercial ketchup, mustard, spices b) commercial vinegar c) commercial olive oil

Please indicate how many times per week you consume the following foods:

Coffee (including decaf.) _____ Fried foods _____ Cow's Milk _____ Bread (store-bought) _____ Black tea _____ caffeine drinks _____ Fast food _____ Yogurt _____ Crackers (store-bought) _____ Soft drinks (colas, etc.) _____ Potato or corn chips _____ Ice cream _____ Bagels (store-bought) _____ Drinks with Artificial Sweeteners _____ Roasted nuts _____ Cottage cheese _____ Buns (store-bought) _____ Alcohol (wine, beer, etc.) _____ Mayonnaise _____ Sour cream _____ Pasta (store-bought) _____ Chocolate _____ Margarine _____ Cheese (commercial) _____ Muffins (store-bought) _____ Candy _____ pastries _____ sweets _____ Peanut butter (commercial) _____ Cookies (store-bought) _____

Food Habits

1. Eating Out Do you eat out at restaurants? _____ If yes, how often? _____ Where? _____
What type of food do you eat at restaurants? _____

2. Home Meals Do you prepare meals at home? _____ If so, how often? _____
If yes, what type of food do you prepare? _____

3. Meal Habits Do You: [circle] a) skip meals often b) have irregular eating times c) Don't eat past 7 PM

4. MSG Do you avoid food/drinks that list "natural flavors" (which means hidden MSG) on the label? _____

5. Water Do you drink tap water? _____ What brand of drinking water do you use? _____

If you have a home water purifier, when was the cartridge last changed? _____

Typical Diet: Please fill out your typical diet for the last few weeks. Please be as detailed as possible.

(For example, instead of writing "chicken," identify what brand and how it was made such as "baked Foster Farms chicken." Instead of writing "salad," identify what it's made of, such as "salad made with organic baby green lettuce, commercial cherry tomatoes and Olive Oil.") PLEASE, BE HONEST!

BREAKFAST: (Time eaten: _____)

LUNCH (Time eaten: _____)

DINNER (Time eaten: _____)

SNACKS (Time eaten: _____)

Bedroom/Sleep Considerations

1. Bedding Materials. What type of sheets and blankets do you use? _____

(i.e. 100% cotton, silk, polyester, poly-blends, wool, etc.)

What type of pillow do you use? _____

2. Mattress. What type of mattress do you sleep on? _____

(such as box springs, synthetic, futon, latex, etc.)

3. Head Direction. What direction does the top of your head point when you sleep?

(i.e. south, north, northwest, etc.)

4. Darkness. Do you sleep with the curtains drawn tightly (so the room is very dark) or is

there considerable light in the room when you sleep? _____

If yes what? _____

5. **Electrical Appliances.** Is there a computer, TV or electrical appliance near your bed? _____

If so, how far away? _____

Are any electrical appliances left on in the room when you sleep (such as a TV/computer)? _____

6. **Clock-Radio.** Do you sleep with a clock-radio near your head (within one to two feet)? _____

7. **Windows.** Do you sleep near a window? _____
What direction does the window face? _____

8. **Alarm.** Do you sleep with a whole-house alarm turned on (which uses infrared beams/sensors within the house)? _____

9. **EMF Exposure.** Do you sleep with your head at least one foot away from the wall? _____

Electrical Devices on Body

1. **Hearing Aid.** Do you wear a hearing aid? _____
If yes, which ear(s)? _____

2. **Watch.** Do you wear a battery-operated watch? _____

3. **Pacemaker.** Do you wear a pacemaker? _____

4. **Other.** Do you wear any other electrically-powered devices on your body? _____
If yes, what and where? _____

EMF Exposure

1. **Cell Phone.** Do you use a cell phone? _____
If yes, how often? _____

2. **Cell Phone Tower.** Do you live or work within 1/2 mile of a cell phone tower? _____

3. **Transformers.** Do you live or work within 100 ft. or less of a power transformer (on a telephone pole)? _____

4. **Pager.** Do you wear a pager? _____
If yes, how often? _____

Toxic Body Exposure

1. **Nail Polish.** Do you wear fingernail or toenail polish? _____

Have you ever worn fingernail or toenail polish? _____

If yes, for how long? _____

2. **Toxic Chemicals.** Have you ever had toxic chemicals spill on your body? _____

HEALTH GOALS

What is Your Most Important Health Goal?

What is Your 2nd Health Goal?

