Confidential Health History Questionnaire

Please write or print clearly, and return it 24 hours before our appointment

Email: [lawler.marnie@gmail.com] or mail to [51 Eastern Avenue, Essex, MA 01929]

Name: ______________________________

Address: ______________________________

Email address: ______________ How often do you check email? ________

Telephone – Work: __________ Home: __________ Cell: __________

Age: ______ Height: ______ Date of Birth: ______ Place of Birth: __________

Current weight: ________ Weight six months ago: ________ One year ago: ________

Would you like your weight to be different? ________ If so, what? __________

Relationship status: __________ Children? __________ Pets? __________

Occupation: ______________________ Hours of work per week: ______

Hobbies / activities: ______________________________

What is your ancestry? ______________________ Blood type (if known): ______

Referred by: ______________________

Please list your main health concerns: ______________________________

____

____

____

Any other concerns and/or goals? ______________________________

____

____

At what point in your life did you feel best? ______________________________

____

Do you sleep well? ________ How many hours? ________ Time to bed: __________ Time wake up: ____________

Do you wake up at night? _________ If so, why? ________________________________ At what time? ____________

How do you feel when you wake up? ____

Do you have any digestive issues? Please explain: ____

Do you experience discomfort (pain, gas, bloating, heartburn) after eating? Please explain: ____

# of bowel movements per day: ____

Do you ever experience constipation or diarrhea? Please explain: ____

Any known food allergies or sensitivities? Please list: ____

For women only:

Age of your first period: ____________________ Are your periods regular? ____________________________

How many days in your flow? ____________________ How frequent? ____________________________

Do you experience PMS? If yes, please describe symptoms ____

____

Birth control history: ____

How many children have you delivered and how were they born? (vaginally/C-section) ____

____

Were there complications associated with these births? Please explain: ____

____

Did you receive antibiotics during labor? ____

Have you had difficulty conceiving? ____

Do you experience yeast infections or urinary tract infections? Please explain: ____

For men only:

Approximate age of onset of puberty: ____________ # of Children: ____________________

Do you feel your libido is adequate? ____________ Comments: ____________________

Do you wake at night to urinate? ____________ How many times per night? ____________

Do you have difficulty and/or pain with urination? ________ Diminished volume or flow? ____________

Do you enjoy daily activities, or do you feel apathetic/complacent about previously enjoyed sports, hobbies, clubs, games, etc ________

Do you notice feeling more agitated/irritable than previously? ______________________________

Do you feel less assertive in daily life than previously? ______________________________

Medical history & current care

Please list any surgeries, accidents, injuries, hospitalizations, or childhood diseases you have had along with the type and the date:

Are you currently under a practitioner's care for a specific health issue? ____________________

If so, what treatments are you receiving? ______________________________

Please list any vitamins/minerals/herbs/homeopathic remedies, prescription/non-prescription medications, diet pills, or any other supplements? Please list all below including brand names and dosage.

Please list any known allergies to medications or herbs: ______________________

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What's your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

What percentage of your food is home cooked? __________ Do you cook? __________

Where do you get the rest from? ______________________

How much water do you drink per day? ______________________

Do you drink caffeinated drinks? ______ Which ones, how much, and how often? __________

Do you drink alcoholic drinks? ______ Which ones, how much, and how often? __________

Do you drink soda (diet or reg)? ______ Which ones, how much, and how often? __________

Do you crave sugar, salt, coffee, cigarettes, alcohol, or have any major addictions? ______________________

____

What role do sports and exercise play in your life? ______________________

____

Describe your weekly cardio training routine:

Exercise	Intensity	Duration	# times/week

Describe your weekly strength training routine:

Exercise	Intensity	Duration	# times/week

Describe any other exercises / sports / physical activities you do:

Exercise	Intensity	Duration	# times/week

Do you smoke? ____________ How much and how often? ______________________

If you used to smoke but quit – why, how and when did you quit smoking? ______________________

____

Are you exposed to second-hand smoke? ________ How much and how often? ______________

Have you been exposed to toxic substances at work or home? ______________________

Do you have mercury fillings? ________ Do you plan to have them removed? ______________

Family health history

How is your mother’s health? ______________________

____

How is your father's health? ______________________________

____

Has a **blood-related** family member of yours had any of the following health conditions? If yes, please indicate if it was their cause of death and specify their relationship to you (mother, father, sibling, maternal or paternal grandparent).

Condition		Relationship to you:	
Alzheimer's	________	Relationship to you:	________
Asthma	________	Relationship to you:	________
Autoimmune disease (specify type)	________	Relationship to you:	________
Cancer (specify type)	________	Relationship to you:	________
COPD	________	Relationship to you:	________
Dementia	________	Relationship to you:	________
Diabetes (specify type)	________	Relationship to you:	________
Emphysema	________	Relationship to you:	________
Epilepsy	________	Relationship to you:	________
Gall bladder condition	________	Relationship to you:	________
Glaucoma	________	Relationship to you:	________
Heart attack (specify type)	________	Relationship to you:	________
Heart condition (specify type)	________	Relationship to you:	________
High blood pressure	________	Relationship to you:	________
Kidney disease	________	Relationship to you:	________
Liver disease	________	Relationship to you:	________
Mental illness (specify type)	________	Relationship to you:	________
Migraines	________	Relationship to you:	________
Obesity	________	Relationship to you:	________
Osteoarthritis	________	Relationship to you:	________
Osteoporosis	________	Relationship to you:	________
Parkinson's disease	________	Relationship to you:	________

Rheumatoid arthritis ______________________ Relationship to you: ____________________

Stroke ______________________ Relationship to you: ____________________

Thyroid condition (specify type) ______________________ Relationship to you: ____________________

Ulcer (specify type) ______________________ Relationship to you: ____________________

Other ______________________ Relationship to you: ____________________

Other ______________________ Relationship to you: ____________________

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? ____________

Have you tried addressing your current health concerns in the past? If yes, what happened? ____________

Do you feel ready to make the changes necessary to achieve your health goals? ____________

Anything else you want to share? ______________________