

Health and Lifestyle Questionnaire

All information you provide in this questionnaire will be treated as private and confidential. It will only be released to other individuals with your written permission.

Name _____ Date of Birth _____ Age _____ Sex _____

Address _____ City/State/Zip _____

Phone _____ Fax _____ Email _____

Occupation / Employer _____ Church / Religion _____

Marital Status: single married divorced widowed

Spouse's name _____ Ages of children _____

What is the best time and method to get in touch with you? _____

What is your height _____ Weight _____ Desired weight _____

Please list your main health concerns or issues:

- 1.
- 2.
- 3.
- 4.

What active medical conditions are you currently receiving treatment for:

Condition	Date started	Current Treatment
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1.

2.

3.

4.

5.

6.

Please list all drug allergies: (specify if "none")

Please list any non-drug allergies you experience such as food allergies, environmental, animals, etc:

Specify all medications you are currently using: (include hormones and non-prescription medicines)

Name _____ Dose _____ Times/Day _____

Name _____ Dose _____ Times/Day _____

Name _____ Dose _____ Times/Day _____

Name _____ Dose _____ Times/Day _____

Name _____ Dose _____ Times/Day _____

Name _____ Dose _____ Times/Day _____

Name _____ Dose _____ Times/Day _____

List all surgical procedures you have had (with dates) – include cosmetic surgery:

Are you currently receiving other alternative or “natural” therapies:

- chiropractic
- acupuncture
- therapeutic massage
- homeopathy
- colonics
- chelation
- kinesiology
- juicing
- herbal (specify _____)
- other _____

Do you or your close family members have a history of:

	<u>Myself</u>	<u>Family Member (specify who)</u>
Cancer	<input type="checkbox"/>	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/> _____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> _____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/> _____
Lung disease	<input type="checkbox"/>	<input type="checkbox"/> _____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/> _____
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/> _____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/> _____
Bowel disease	<input type="checkbox"/>	<input type="checkbox"/> _____
Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/> _____
Alcohol / drug addiction	<input type="checkbox"/>	<input type="checkbox"/> _____
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/> _____

Have you been exposed to potentially harmful chemicals, metals, or radiation at home or at work? (for example – dental fillings, pesticides, radioactivity, solvents)

Exposed to: _____ When Exposed: _____ How Exposed: _____

Smokers: Type smoked _____ Amount per day _____ Age started ____ Age stopped ____

Alcohol consumption: Drinks/week _____ Typical beverages _____

Coffee: Cups/day _____ Diet Soda or other drinks with Aspartame/day _____

Recreational Drug Use _____

Exercise Summary: Are you currently involved in an exercise program? Yes No

Describe your current exercise _____

Describe and limitations or problems you have with activity or exercise _____

Do you have exercise equipment at home? Yes No

Are you an active member of a health club or gym? Yes No

Are you presently receiving physical therapy? Yes No

If yes, describe:

What sort of exercise program would you prefer to do if there were no limitations? (describe)

Sleep History:

- Number of hours you typically sleep each night _____
- Do you usually sleep well and awaken refreshed? Yes No
- Do you have trouble falling asleep? Yes No
- Do you often wake during the night and have trouble falling asleep again? Yes No
- Do you have a history of snoring or sleep apnea? Yes No
- Do you get sleepy or take naps during the day? Yes No
- Do you use sleeping medication or other aids to help fall asleep? Yes No

Nutrition Summary:

Describe any specific philosophy or approach you have to nutrition and diet:

What special diets have you tried in the past? What results?

What foods do you consistently overeat?

- Do you crave
- sugar and sweets Yes No
 - breads and pasta Yes No
 - chocolate Yes No
 - salty foods Yes No
 - fatty foods Yes No
 - other _____

Describe your nutrition on a typical "good day" (please list a typical menu of food you eat)

Breakfast (time _____)

Morning snack (time _____)

Lunch (time _____)

Afternoon snack (time _____)

Supper (time _____)

Evening snack (time _____)

Describe your nutrition on a typical "bad day"

Breakfast (time _____)

Morning snack (time _____)

Lunch (time _____)

Afternoon snack (time _____)

Supper (time _____)

Evening snack (time _____)

Please list any vitamins, herbals, or other supplements you currently take: (use additional page if necessary)

On a scale of 1 to 10, please rate the following areas in your life at the present time:

	Worst		Poor		OK		Pretty Good		Best	
My energy level is:	1	2	3	4	5	6	7	8	9	10
My appetite is:	1	2	3	4	5	6	7	8	9	10
My diet is:	1	2	3	4	5	6	7	8	9	10
My sleep is:	1	2	3	4	5	6	7	8	9	10
My exercise is:	1	2	3	4	5	6	7	8	9	10
My symptoms are:	1	2	3	4	5	6	7	8	9	10
My attitude is:	1	2	3	4	5	6	7	8	9	10
My overall health is:	1	2	3	4	5	6	7	8	9	10

Females Only:

Date of Last Menstrual period: _____
 Date of last: Breast exam _____ PAP smear _____ Mammogram _____
 Do you have issues or concerns with: Describe:

- Hormone balance Yes No
- Missed or irregular periods Yes No
- Hot flashes Yes No
- Premenstrual symptoms Yes No
- Infertility Yes No

Males and Females:

When was the approximate date that you most recently had the following:

- Complete physical exam _____
- Diagnostic blood tests _____
- Dental check-up _____
- Vision exam _____
- Hearing test _____
- EKG _____
- Exercise stress test (treadmill or other) _____
- Sigmoidoscopy or Colonoscopy _____
- Stool exam for blood _____
- Lung function tests _____
- Bone density scan _____

Were any of the above tests abnormal? Please describe:

Who is your primary health care provider? _____ Specialty? _____

Their office phone number: _____ Do you give permission for Dr. Billica to discuss your medical situation with your primary health care provider? Yes _____ No _____

Your signature _____ Date _____

DIGESTIVE TRACT	<input type="checkbox"/>	Nausea, vomiting	
	<input type="checkbox"/>	Diarrhea	
	<input type="checkbox"/>	Constipation	
	<input type="checkbox"/>	Bloated feeling	
	<input type="checkbox"/>	Belching, passing gas	
	<input type="checkbox"/>	Heartburn, indigestion	
	<input type="checkbox"/>	Intestinal, stomach pain	Total <input type="text"/>
JOINTS / MUSCLES	<input type="checkbox"/>	Pain or aches in joints	
	<input type="checkbox"/>	Arthritis	
	<input type="checkbox"/>	Stiffness or limitation of movement	
	<input type="checkbox"/>	Pain or aches in muscles	
	<input type="checkbox"/>	Feeling of muscle weakness	Total <input type="text"/>
GENITOURINARY	<input type="checkbox"/>	Frequent or urgent urination	
	<input type="checkbox"/>	Having to get out of bed to urinate at night	
	<input type="checkbox"/>	Difficulty starting or stopping urine stream	
	<input type="checkbox"/>	Urinary incontinence	
	<input type="checkbox"/>	Genital itch, discharge, or sores	
	<input type="checkbox"/>	Vaginal yeast infections (women)	Total <input type="text"/>
WEIGHT	<input type="checkbox"/>	Binge eating / drinking	
	<input type="checkbox"/>	Craving certain foods	
	<input type="checkbox"/>	Excessive weight, inability to lose weight	
	<input type="checkbox"/>	Compulsive eating	
	<input type="checkbox"/>	Water retention	
	<input type="checkbox"/>	Underweight, inability to gain weight	Total <input type="text"/>
ENERGY / ACTIVITY	<input type="checkbox"/>	Fatigue, sluggishness	
	<input type="checkbox"/>	Apathy, lethargy	
	<input type="checkbox"/>	Hyperactivity	
	<input type="checkbox"/>	Restlessness	Total <input type="text"/>
MIND	<input type="checkbox"/>	Poor memory	
	<input type="checkbox"/>	Confusion, poor comprehension	
	<input type="checkbox"/>	Poor concentration	
	<input type="checkbox"/>	Poor physical coordination	
	<input type="checkbox"/>	Difficulty in making decisions	
	<input type="checkbox"/>	Stuttering or stammering	
	<input type="checkbox"/>	Slurred speech	
	<input type="checkbox"/>	Learning disabilities	Total <input type="text"/>
EMOTIONS	<input type="checkbox"/>	Mood swings	
	<input type="checkbox"/>	Anxiety, fear, nervousness	
	<input type="checkbox"/>	Anger, irritability, aggressiveness	
	<input type="checkbox"/>	Depression	
	<input type="checkbox"/>	Lack of sex drive, decreased libido	
	<input type="checkbox"/>	Suicidal thinking or behavior	Total <input type="text"/>
OTHER	<input type="checkbox"/>	Frequent illness, slow recovery from illness	
	<input type="checkbox"/>	Fever, chills, or night sweats	
	<input type="checkbox"/>	Cold hands or feet	
	<input type="checkbox"/>	Burning, numbness, tingling in hands or feet	
	<input type="checkbox"/>	Excessive thirst	
	<input type="checkbox"/>	Sleep problems, insomnia	
	<input type="checkbox"/>	Food intolerances, food allergies	Total <input type="text"/>

OVERALL TOTAL _____