Health Questionnaire

Print name: _____ Age _____
First Last

Best phone # _____ ☐ Cell ☐ Home ☐ Work // 2nd Best # _____

Email _____ ☐ Do NOT add to email list.

Why are you here? What do you want to resolve? _____

_____

Electronic devices in body? _____ Body parts surgically removed? _____

CURRENT CHALLENGES

Abnormal Cells/Cancer	☐ YES	Environmental Allergies	☐ YES	Nerve Pain/Numbness	☐ YES
Acne	☐ YES	Epilepsy	☐ YES	Not Sleeping Well	☐ YES
Anxiety/Panic Attacks	☐ YES	Fatigue	☐ YES	Obesity	☐ YES
Asthma/Bronchial	☐ YES	Frequent Colds	☐ YES	Pain	☐ YES
AutoImmune Condition	☐ YES	Hair Loss	☐ YES	PMS	☐ YES
Back Pain	☐ YES	Headaches/Migraines	☐ YES	Pregnant	☐ YES
Bladder Issues	☐ YES	Heart Issues	☐ YES	Prostate	☐ YES
Blood Sugar	☐ YES	Heartburn	☐ YES	Restless Legs	☐ YES
Bone Loss	☐ YES	High Blood Pressure	☐ YES	Seasonal Allergies	☐ YES
Bowel Issues	☐ YES	Infertility	☐ YES	Sinus Issues	☐ YES
Breast Pain/Lump	☐ YES	Joint Pain	☐ YES	Skin Issues	☐ YES
Breathing/Lung Issues	☐ YES	Kidney Issues	☐ YES	Teeth Problems	☐ YES
Chest Pain	☐ YES	Libido Issues	☐ YES	Thyroid Issues	☐ YES
Circulation Issues	☐ YES	Liver Issues	☐ YES	Tired/No energy	☐ YES
Constipation/Diarrhea	☐ YES	Medications	☐ YES	Trauma/Emotional Pain	☐ YES
Depression	☐ YES	Memory	☐ YES	Urinary Urgencies	☐ YES
Digestion/Bloating	☐ YES	Menopause	☐ YES	Vertigo/Dizziness	☐ YES
Emotional Issues	☐ YES	Mood Swings	☐ YES	Water Retention	☐ YES

NUMBER PER WEEK

Alcohol	_____	Coffee	_____	Soda	_____
Aspartame (blue)	_____	Eat Fish	_____	Splenda (yellow)	_____
Bowel movements	_____	Exercise	_____	Sweet tea	_____
Eat bread	_____	Milk	_____	Sweets/Sugar	_____
Cigarettes	_____	Saccharine (pink)	_____	Water	_____

DO YOU?

Have silver amalgams?	☐ YES	Take a MultVitamin/Mineral?	☐ YES	Eat a lot of fast food?	☐ YES
Take fish oil?	☐ YES	Have food allergies?	☐ YES	Try to eat healthy?	☐ YES

OTHER

Diet is mostly (circle 2 highest): Meat * Vegetables * Fruits * Fatty foods * Carbs * Grains * Sweets * Junk Food

Do you usually get the flu shot? _____ Known food allergies? _____

Do you have a family history of alcoholism, depression, suicide, schizophrenia, or other mental illness? _____

Name of medication?	Medical reason for taking it?	Amount?	How long?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Based upon **the past one to two months**, please select the appropriate number, from '0 - 3' on all questions (**0 as least/never/no** and **3 as most/always/yes**).

SMALL INTESTINE	0	1	2	3
Do you have any known food sensitivities?	0	1	2	3
Do specific foods make you feel tired or bloated?	0	1	2	3
Do you experience hives or have occasional skin issues?	0	1	2	3
Do you experience sinus congestion or "stuffy head"?	0	1	2	3
Do you alternate between constipation and diarrhea?	0	1	2	3
Do you have a history of irritable bowel or bowel discomfort?	0	1	2	3
Are there foods you crave and it would be very hard for you to give up?	0	1	2	3
Do you use regularly over-the-counter pain medications?	0	1	2	3
Does eating roughage and fiber cause constipation?	0	1	2	3
Do you experience excessive gas?	0	1	2	3
Do you experience nausea on a regular basis?	0	1	2	3
Do you eat a lot of corn chips and other corn products?	0	1	2	3

LARGE INTESTINE (COLON)	0	1	2	3
Do you experience issues with your anus being itchy?	0	1	2	3
Have you taken antibiotics within the last few months?	0	1	2	3
Have you been on antibiotics for at least a month or more?	0	1	2	3
Are your stools hard or difficult to pass?	0	1	2	3
Do you have less than one or more than 3 bowel movements per day?	0	1	2	3
Are your stools not formed (loose) or are thin or like ribbon shaped?	0	1	2	3
Do you ever have excessive foul smelling bowel gas or stools?	0	1	2	3
Is it painful to press along the outer sides of your thighs?	0	1	2	3
Do you have cramping in your lower abdominal region?	0	1	2	3
Do you often have the feeling that your bowels do not empty completely?	0	1	2	3
Do you have constipation or diarrhea?	0	1	2	3
Do you ever have a need for laxatives?	0	1	2	3

I understand that no doctor patient relationship exists, but only a contract member to member Association relationship. I understand that no prescription or medication, or medical advice should be altered without consulting with my medical doctor. I agree to indemnify and hold harmless the Member Consultant and Getting Well Naturally Private Healthcare Membership Association from any and all claims and damages of every kind to myself or any person or property arising out of or attributed to the services performed or received.

Signature _____ Date: _____