An Integrated Health Resource

Health Questionnaire

Name:_____ Date:_____

Thank you for choosing Quintessential Health Care where you will discover much about your health and how your body functions. We welcome any questions you may have during the course of your participation.

Below are questions that will assist us in evaluating your health needs. Please check all applicable boxes.

Sleep: How is your sleep?
- ❑ restful
- ❑ restless
- ❑ hard to get to sleep
- ❑ wake up often
- ❑ get up during the night
- ❑ bad dreams
- ❑ other:_____

Digestion: How is your digestion?
- ❑ adequate
- ❑ poor
- ❑ acid reflux
- ❑ burp often
- ❑ bloating
- ❑ burning or pain in stomach

Exercise:
- ❑ daily
- ❑ 4-5 times per week
- ❑ 2-3 times per week
- ❑ cardiovascular
- ❑ resistance
- ❑ sports
- ❑ enjoy exercising

Sunlight:
- ❑ receive daily sunlight outside
- ❑ receive daily sunlight through windows
- ❑ fluorescent lighting in home/work

Eyewear:
- ❑ contact lenses
- ❑ glasses
- ❑ just for reading
- ❑ 2-3 hours/day
- ❑ 4-6 hours/day
- ❑ 8+ hours/day

Electromagnetic Exposure:
- ❑ watch TV 1+ hours daily
- ❑ work with computers
- ❑ hours talking on phone: _____
- ❑ hours talking on cell phone: _____
- ❑ wear a pager
- ❑ wear a headset
- ❑ ride in a truck/car/vehicle 1+ hours daily
- ❑ near electrical equipment for long periods (copy machines, high power lines, etc.)

Chemical Exposure:
- ❑ work with chemicals
- ❑ handle chemicals directly
- ❑ chemicals around the workplace
- ❑ smoker
- ❑ recreational drug use, past or present

Stress:
- ❑ minimal
- ❑ moderate
- ❑ heavy
- ❑ severe
- ❑ family stress
- ❑ job stress

Dental work:
- ❑ silver fillings
- ❑ composites
- ❑ extractions: wisdom, bicuspids, etc.
- ❑ bridgework
- ❑ partial or full dentures
- ❑ gold crowns or inlays
- ❑ stainless steel crowns or inlays
- ❑ porcelain crowns or inlays
- ❑ veneers
- ❑ root canals
- ❑ posts
- ❑ implants
- ❑ temporaries
- ❑ braces
- ❑ bleeding gums
- ❑ sensitive teeth
- ❑ bad bite
- ❑ new cavities
- ❑ dental surgery
  describe: _____
- ❑ need for further dental work
  describe: _____

Nervous system:
- ❑ lack of focus
- ❑ poor concentration
- ❑ forgetfulness
- ❑ jagged speech
- ❑ anxiety
- ❑ insomnia
- ❑ depression
- ❑ feeling wired at times

Bowels:
How are your bowel eliminations?
How often?
- ❑ 3 times daily
- ❑ once per day
- ❑ skip days

Amount
- ❑ normal
- ❑ too little
- ❑ too large

Color
- ❑ brown
- ❑ black
- ❑ whitish
- ❑ Other
- ❑ lots of mucus
- ❑ lots of gas
- ❑ foul smell
- ❑ intestinal cramping
- ❑ international travel

Consistency
- ❑ normal
- ❑ too hard
- ❑ very soft
- ❑ diarrhea
- ❑ alternating diarrhea/constipation

Urination:
How are your daily urinations?
- ❑ every 2 to 3 hours
- ❑ too frequent
- ❑ sense of urgency
- ❑ too small amount
- ❑ too large amount
- ❑ burning
- ❑ dribbling
- ❑ up at night several times

Women only:
- ❑ pregnant
- ❑ breast feeding
- ❑ date of last period: _____
- ❑ menopause
- ❑ hysterectomy
- ❑ monthly periods regular (28 days)
- ❑ days of your menstrual flow _____
- ❑ have taken birth control medication
- ❑ bone loss/osteoporosis

Symptoms associated with your period:
- ❑ cramping
- ❑ bloating
- ❑ feeling weak
- ❑ mood swings
- ❑ cravings
- ❑ heavy bleeding
- ❑ back pain
- ❑ headaches
- ❑ bright red blood
- ❑ dark clotty blood
- ❑ painful breasts
- ❑ painful menses

Men and Women:
- ❑ complications with heart
- ❑ high blood pressure
- ❑ irritability
- ❑ decrease in muscular strength
- ❑ depressive mood
- ❑ feeling burned out
- ❑ decreased libido
- ❑ tire easily
- ❑ prostate trouble (**MEN ONLY**)

Medications or supplements you are currently taking:

_____

_____

List below your 4 main health concerns in order of importance:

1) _____
2) _____
3) _____
4) _____

Describe any scars on your body and their causes.

_____

_____

_____

Please list any surgeries, operations, traumas, car accidents, etc.

_____

_____

_____

_____

_____

Check any areas that apply:

❒ Glasses/Contacts
❒ Arthritis
❒ Blood Pressure High
❒ Skin Irritations
❒ Epilepsy
❒ Poor Circulation
❒ Asthma
❒ Eczema or Psoriasis
❒ Contagious Disease (please explain):_____

❒ AIDS
❒ Neck Pain
❒ Blood Pressure Low
❒ Swollen Joints
❒ TMJ Dysfunction
❒ Cold sores/Herpes
❒ Claustrophobic
❒ Hepatitis

Are you currently under the care of a physician? ❒ Yes ❒ No If so, for what condition(s)?

_____

_____