Four Forces Wellness, Inc.

Date: _____

Health Questionnaire

Last name:_____ First Name: _____

Address:_____

City: _____State: _____Zip:_____

Email address: _____

Skype contact (if applicable):_____

Home Phone: _____ Work Phone:_____

Cell Phone:_____

What numbers are best for detailed messages?

_____

What is your preferred method of contact?

_____

Gender: _____DOB: _____

Place of Birth: _____

Genetic background (please select all that apply):

African American Native American Mediterranean

Asian Caucasian Northern European Other _____

What would you like help with at this time? _____

How did you find out about Four Forces Wellness?

_____

Would you like to receive news and recipes from Four Forces Wellness? ____

Personal History

What health conditions are you experiencing?	How long have you had them?

Primary Physician:

Name:_____

Address:_____

Phone number: _____ Fax number: _____

Please list other practitioners that you are seeing:

_____

_____

_____

Have you had prolonged use of any medication in the past (prednisone, acid blocking drugs, tylenol, antibiotics, etc)? Please describe.

_____

_____

List major traumas, major or minor surgeries, and hospitalizations:

_____

_____

Medications and Supplements *Please list all **prescription medications** as well as **nutritional supplements and herbs** you are currently taking. Use a separate sheet if needed.*

Name	Dosage	Frequency	Length of time	Purpose

Physical Activity and Lifestyle

What kind of physical activities do you do?

_____

Activity	**Type(s)**	**Days per week**	**Duration**
Stretching/Yoga			
Strength Training			
Aerobic/Cardio			
Other			

Are you satisfied with your energy level? _____

Are there any problems/limitations that inhibit your physical activity?

_____

What do you do for relaxation?

_____

How many hours of sleep do you get per night/day? _____

How well do you sleep? _____

Relationship Status: _____ # of times Married:_____

Divorced:_____ Widowed:_____

Current Occupation:_____ How many years? _____

Hours per day/week?_____/_____

How do you feel about your work?

_____

What are your passions and interests?

_____

On a scale of 1-10, with 1 being low and 10 being high, how stressful is your

Work: _____ Current health status: _____ Social/family situation:_____

Life in general:_____

What do you believe you can do to make a difference in your current health?

_____

Environmental information: How often are you exposed to any of the following? *Indicate the number of times per **day, week, or month**. If previously, but not currently exposed, check the column marked "**P.**"*

Exposure	Day	Wk	Mo	P	Exposure	Day	Wk	Mo	P
Cigarette smoke					Wood stove				
Recreational drugs					Perfumes/hair dyes				
Pet dander					Car exhaust				
Mold					Pesticides				
Cleaning products					Dry cleaned clothes				
Teflon or aluminum pans					Bottled water				
Photo developing					Harsh chemicals				

Nutrition

Please describe any nutrition consultations you may have had before this one:

_____

Please list any **food** allergies:

_____

Please list **non-food** and **environmental** allergies:

_____

Please list any special dietary restrictions/habits you have:

_____

What foods do you crave if any?

_____

What are your favorite foods?

_____

Where do you shop for groceries?

_____

Please describe any changes you have made to your diet to improve your health:

_____

How would you describe your relationship with food?

_____

Height:_____ Weight: _____ Ideal Weight: _____

Highest Adult weight: _____ Year: _____

Lowest Adult Weight: _____ Year: _____

Please describe any issues you have around weight:

_____

Food Frequency: How often do you eat or do the following? Indicate the number of times per **day** or **week**, as applicable.

Meals per day: _____ Snacks per day: _____ Water _____ ounces per day

Fats and oils: ____ x d / wk *What kinds?*_____

Food/Action	**Day**	**Week**	**Food/Action**	**Day**	**Week**
Prepare meals at home			Eat nuts/seeds		
Eat lentils/beans			Eat yogurt		
Dairy milk/cheese			Other milk		
Bread			Whole grains		
Pasta			Chips/crackers, etc.		
Candy			Fast food		
Red meat			Chicken/turkey		
Deli meat			Fish		
Shellfish			Organ meat		
Soy products			Eggs		
Vegetables			Fruits		
Coffee (decaf or regular?)			Herb or other tea		
Soft drinks (diet or regular?)			Alcoholic drinks		
Frozen dinners			Eat fast or on the run		

NUTRITION: 3-Day Food Diary

1) Please write down all food and drink, including water
2) Record information as soon as possible after the food has been consumed
3) Do not change your eating behavior. The purpose of this food record is to analyze your current eating habits.
4) Describe the food or beverage consumed, e.g., milk - what kind? (soy, almond, whole, 2%, or nonfat, etc.); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc. 5) Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.

	Day 1	**Day 2**	**Day 3**
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

Symptom Review: Please check the appropriate boxes for symptoms noticed in the past year, and any major problems that you had previously, but no longer have.

FS=Frequent and severe FS=Frequent, not severe,

OS=Occasional and severe ON=Occasional, not severe

PR=Previously, but not any more

Upper GI Symptoms	**FS**	**FN**	**OS**	**ON**	**PR**
Nausea in evenings					
Indigestion after eating					
Duodenal ulcer					
Foul burps					
Butterflies in stomach					
Skip breakfast					
Don’t finish meals					
Eat to calm down					
Drink alcohol					
Poor appetite					
Nausea in mornings					
Excess salivation					
Stomach ulcer					
Strong, demanding hunger					
Bitter taste or bad breath in morning					
Acid indigestion at night					
Frequent mouth or cold sores or receding gums					
Mouth dry, or difficulty swallowing					

Lower GI Symptoms	**FS**	**FN**	**OS**	**ON**	**PR**
Tongue coated					
Constipation, need for laxatives					
Light colored, hard stools					
Intestines bloated, gassy					
Constipation with hemorrhoids or pain					
Constipation with hard, marble-like stools					
Alternating constipation and diarrhea					
Stools loose with gas					
Digestion unusually rapid					
Loose stools when tired/stressed					
Dark, soft stools					
Quick defecation after eating					
Liver Symptoms	**FS**	**FN**	**OS**	**ON**	**PR**
Dry or scaly skin					
Hay fever or asthma					
Craves fruit or sweets					
Frequent trouble digesting fats					
Acne on face & buttocks					
Seem to have low blood sugar					
Hepatitis					
Heavy use of alcohol or chemical solvents					
Psoriasis, eczema, dermatitis					
Frequent minor illness					
Don’t sweat					

Moist, sometimes oily skin					
Hives from food or drugs					
Craves protein, fats					
Fever with sweat when sick					
Renal and Urinary Symptoms	**FS**	**FN**	**OS**	**ON**	**PR**
Faintness or dizziness when standing quickly					
Frequent flushing or blushing					
Moderate low blood pressure					
Frequent thirst					
Craving salt					
Urine always light colored					
Dull ache after urination					
Frequent bladder infections					
Frequent or urgent urination, small amounts					
Mucus in urine					
Pulse roars in ears when standing quickly					
Frequent water retention					
Urine usually dark					
Moderate high blood pressure					
Infrequent urination, large amount					
Cardiovascular and Lymphatic Symptoms	**FS**	**FN**	**OS**	**ON**	**PR**
Fast, light pulse					
Tend to be cold					
Sometimes dizzy or faint					
Hands cold, clammy or dry					

Hypertension not responding to diuretics					
Injuries or colds heal slowly					
Cold hands and feet					
Slow, strong pulse					
Frequent physical activity					
Tend to be warm					
Hands warm, sweaty					
Palpitations during adolescence or before menses					
Hypertension responds to diuretics					
Injuries or colds heal quickly					
Respiratory Symptoms	**FS**	**FN**	**OS**	**ON**	**PR**
Shortness of breath when standing or walking					
Tobacco smoker					
Difficulty swallowing					
Difficulty coughing up mucus					
Rapid, shallow breather					
Sometimes wake up choking or gasping for breath					
Yawns frequently					
Frequent chest colds					
Easy coughing of mucus					
Sometimes hyperventilates					
Mucus Membrane and Skin Symptoms	**FS**	**FN**	**OS**	**ON**	**PR**
Dry scalp or hair					
Lips often dry and chapped					
Sores, cracks, fissures in mouth, vagina or anus					

Oily scalp or hair					
Sweat freely with strong scent					
Food causes distress as it passes					
Deep skin eruptions, not coming to a head					
Cracks, fissures on heel, elbow, feet, heal poorly					
Oily skin, facial acne					

Sexuality and Reproduction

Are you sexually active? _____Birth control method: _____

Males *Please check all that apply:*

__ Difficult to maintain erections when in the mood

__ Benign prostatic hypertrophy

__ Pain or ache after orgasm

Females *Please check all that apply:*

__Cycle more than 28 days

__Miss some periods

__Menses slow starting with cramps

__Menstruation always lengthy

__Abnormal Pap Smear

__History of PID, cervicitis

__Cycle less than 28 days

__Water retention before menses

__Constipation before, loose stools after menses start

__Always hungry before menses

__Breast tender before menses

__Palpitations before menses

__Miscarriages, problem pregnancy

__Tried, couldn't take birth control pills

Number of Children/Live Births: _____

Any chance you may be or may try to get pregnant? _____

Date of Last Menses:_____

General

Mark “1” if somewhat applies. Mark “2” if strongly applies.

__ Aluminum cooking vessels
__ Awakens, can’t go back to sleep
__ Bad dreams
__ Blurred vision
__ Brown spots, bronzing of skin
__ Bruises easily
__ Can’t gain weight
__ Can’t lose weight
__ Can’t get started without coffee
__ Chemical or spray poisoning
__ Chronic fatigue, depression
__ Cry easily without seeming cause
__ Depressed for long periods
__ Earaches
__ Eat often or else faint/nervous
__ Eyes often red or inflamed
__ Face, eyes get puffy
__ Facial twitches
__ Gum problems
__ Headaches
__ Headaches in morning, wearing off
__ Heart palpitations after eating
__ Highly emotional
__ Highly controlled
__ Impaired hearing
__ Increase in weight (recent)
__ Lack of sensation somewhere
__ Likes depressants
__ Likes stimulants
__ Lower back pain
__ Muscle cramps
__ Nails split, brittle
__ Nails weak, ridges
__ Nosebleeds frequently
__ Pollution heavy in environment
__ Ringing in ears
__ Pulse speeds up after meals
__ Sensitive to cold weather
__ Sensitive to hot weather
__ Sensitive to high humidity
__ Sensitive to low humidity
__ Sexual desire decreased
__ Sexual desire increased
__ Stuffy nose during the day
__ Stuffy nose in evening or night
__ Tendency to anemia
__ Tremors in hands or neck
__ Varicose veins
__ Weight gain in upper arms, shoulders, back of neck