HEALTH QUESTIONNAIRE

This information is being gathered for research purposes and statistical analysis. No attempt will be made to diagnose, treat, cure, or alleviate your illness. Thank you for responding to and answering all questions. As much as possible this information will be treated as confidential material.

Name: _____ Date: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone: _____ E-Mail: _____
Biographical Data:
Marital Status: S M D W Date of birth: _____/_____/_____ Referred by: _____
Occupation: _____ Religion: _____
Sex: M F Age: _____ Height: _____ Weight: _____ Race: _____

- Record the pH of your Urine and saliva; check them at 6:00 – 7:00 a.m., 11: 00 a. m. 2:00 p.m. & 7:00 –8:00 p.m.

Time:	6:00 –7:00 a.m	11:00 a.m.	2:00 p.m.	7:00-8:00 p.m.	Date _____
Urine					
Saliva					

Section 1: "What's wrong?"

In this section, please try to identify what's wrong with you at the present time. Put the number in the blank that most accurately represents how often you have the indicated trouble (or the severity of the problem). Use the following numbers:

Blank = never 1 = rarely 2 = occasional 3 = sometimes 4 = most of the time 5 = always

Head & Neck

___ headaches
___ light-headedness
___ motion sickness
___ dizziness
___ absent-mindedness
___ forgetfulness
___ black-outs
___ seizures
___ neck pain
___ neck stiffness
___ cracking noises in neck
___ head pain
___ facial pain
___ eye pains
___ eye strain
___ night blindness
___ blurring of the eyes
___ blurred vision
___ double vision
___ red lines in eyes
___ yellow (jaundice) eyes
___ puffiness under the eyes
___ eyes feel gritty
___ excessive eye itching
___ can't focus distant to close
___ wear glasses to read
___ wear glasses to drive
___ wear contacts
___ dark circles under the eyes
___ glare bothers eyes
___ excessive tearing in eyes
___ eyes bulge or protrude
___ have cataracts
___ enlarged (dilated) pupils
___ constricted pupils
___ pupils are of unequal size
___ crossed eyes (muscle weakness)
___ "lazy" eye – drifts outward
___ ringing or noises in the ears
___ deafness R ___ L ___
___ excessive wax build-up in the ears
___ recurrent ear infection
___ wear a hearing aid
___ discharge from ear
___ itching of the nose
___ sinus trouble
___ postnasal drip
___ spontaneous nosebleeds
___ hay fever
___ allergies
___ excessive sneezing
___ frequent colds
___ difficulty breathing through nose
___ change in sense of smell
___ receding gums
___ bleeding gums
___ teeth glassy on ends
___ coated tongue
___ black tongue
___ burning tongue
___ dryness of mouth
___ mouth ulcers (canker sores)
___ cold sores on lips
___ cracked lips
___ change in sense of taste
___ lost sense of taste
___ salty taste in mouth
___ excessive thirst
___ bad breath
___ frequent sore throats
___ swollen glands
___ severe toothaches
___ increased saliva
___ decreased saliva
___ acne
___ hair is dull, no sheen
___ hair falling out
___ baldness
___ premature gray

Arms & Legs

___ shoulder pain R ___ L ___
___ arm pain R ___ L ___
___ leg pain R ___ L ___
___ left arm aches
___ numbness/tingling of arms R ___ L ___
___ numbness/tingling of hands R ___ L ___
___ numbness/tingling of feet R ___ L ___
___ numbness/tingling of legs R ___ L ___
___ numbness/tingling other _____
___ stiffness of joints
___ cold hands/feet
___ feet/ankles swollen in evening
___ hands/fingers swollen in morning
___ athletes foot
___ burning feet
___ painful feet
___ fingernails (circle any problems: split, brittle, rough, soft, ridges)
___ shakiness/tremors
___ muscle weakness in limbs
___ difficulty in walking
___ leg cramps (charley horse)
___ cramps in feet or toes
___ frequent soreness in muscles
___ cracking joints
___ excessive perspiration in feet
___ plantar warts

Section 1: "What's wrong?" (continued)

In this section, please try to identify what's wrong with you at the present time. Put the number in the blank that most accurately represents how often you have the indicated trouble (or the severity of the problem). Use the following numbers:

Blank = never 1 = rarely 2 = occasional 3 = sometimes 4 = most of the time 5 = always

Torso (vital organs)

___ nausea
___ vomiting
___ difficulty swallowing
___ excessive hunger
___ feel shaky if hungry
___ irritable before meals
___ eat when nervous
___ eat when depressed
___ faint feeling when hungry
___ eating relieves fatigue
___ crave sweets or coffee
___ crave other foods
___ poor appetite
___ loss of appetite
___ excessive hiccups
___ cold most of the time
___ hot flashes
___ hot most of the time
___ alternate between hot and cold
___ night sweats
___ slow (poor) digestion
___ too fast digestion
___ constipation
___ diarrhea
___ pain with BM
___ burning with BM
___ hemorrhoids
___ bleeding from rectum
___ BM has unusual consistency
___ irregularity of BM
___ itching of rectum
___ jock itch
___ burning with urination
___ dribbling urine
___ urine has lost its force
___ urine is hard to stop
___ urine is hard to start
___ bladder pain
___ bed-wetting
___ frequency of urination
___ urgent urination
___ blood in urine
___ pus in urine
___ frequent kidney infections
___ frequent bladder infections
___ awaken at night to urinate
___ kidney stones
___ can't find comfortable position in bed
___ foul-smelling urine
___ foul-smelling BM
___ foul-smelling lower bowel gas
___ bloated feeling
___ abdominal swelling
___ abdominal pain or cramps
___ gall bladder pain
___ frequent belching
___ frequent lower bowel gas
___ indigestion/heartburn
___ chest pains
___ shortness of breath
___ rapid heartbeat
___ slow heartbeat
___ heart pounds hard
___ irregular heartbeat
___ high blood pressure
___ low blood pressure
___ varicose veins
___ chronic coughing
___ spitting up phlegm
___ spitting up blood
___ difficulty breathing
___ wheezing
___ low back pain
___ low back ache – especially after sitting or riding
___ pain in tailbone
___ pain between shoulder blades

Female only

___ painful periods
___ irregular cycles
___ excessive flow
___ clots in flow
___ will miss a period
___ backache with period
___ cramps
___ moody with period
___ hot flashes
___ vaginal discharge
___ lumps in breast
___ soreness in breast
___ cyst in breast
___ cyst on ovary
___ depressed before period
___ acne worse at menstruation
___ hair growth on face/body
___ painful intercourse
___ other female problem
_____

Male only

___ prostrate trouble
___ lumps in testicle
___ diminished sexual activity
___ swollen testicles
___ difficulty urinating
___ swelling external genitalia
___ painful external genitalia
___ pain after intercourse
___ impotency
___ other male problem _____

General

___ weight problem
___ fatigue
___ weakness
___ hives
___ anemic
___ chronic fever
___ skin too oily
___ skin too dry
___ skin abnormal color
___ red, scaly patches on skin
___ muscular pains
___ muscular soreness
___ sharp, shooting knife-like pains where? _____
___ spinal curvature
___ faulty posture
___ sluggish in the morning
___ wake up tired
___ lack stamina
___ unusually nervous or jumpy
___ restlessness
___ insomnia
___ nightmares
___ recurrent dreams
___ cry easily
___ lose temper easily
___ excessive worry
___ depression
___ excessive fear
___ stuttering or stammering
___ feel "keyed up"
___ bite fingernails

Do any of these foods upset you?

___ onions
___ cucumber
___ radish
___ garlic
___ cabbage
___ tomato
___ green pepper
___ rich foods
___ greasy foods
___ spicy foods
___ other _____

Section 2: What' right

In this section, please try to identify what's right with you at the present time. Put the number in the blank which most accurately represents how often you have the indicated quality, trait or habit. Use the following numbers:

Blank = never 1 =rarely 2 = occasional 3 = sometimes 4 = most of the time 5 = always

Character quality & traits

___good attitudes
___self-control
___faithfulness
___beneficial service to others
___enthusiasm
___peaceful
___patient
___kindness
___gentleness
___joy
___mercy and compassion
___loving of God
___loving of others
___loving of self
___happiness
___honesty
___accepting of others
___flexibility
___good motivation
___perseverance
___vitality

health & lifestyle habits

___clarity of thought
___good memory
___strength
___endurance/stamina
___freedom of motion
___resistance to illness
___pain-free
___healthful appearance to others
___restful sleep
___feels great
___normal weight
___good eyesight
___good hearing
___good skin tone
___good skin color
___good muscle tone
___regular exercise
___wide variety in diet
___eat breakfast daily
___overeats
___feel stressed at meal

___exhausted at mealtime
___feel stuffed after meal
___avoids junk food
___non-smoker
___non abuser of alcohol
___proper fluid intake
___drinks fluids with meals
___regularity in meals
___temperate in food and drink
___temperate in behavior
___exhausted at the end of day
___normal body temperature
___willing to make changes in diet & lifestyle
___work indoors
___watch TV __hrs./week
___devotional reading __hrs./week
___angry at others
___feel hurt by others
___have enemies
___others _____

Section 3: Past Health Problems and Lifestyle Habits

In this section, please try to respond accurately to the questions. Indicate or fill in the blanks provided with the appropriate response.

Give the names and dates of any medical condition that you have had or currently have. _____

_____

_____

What are you currently being treated for? _____

_____

List all medications that you are currently taking and how long you have been taking each one. _____

_____

_____

List all minerals, vitamins and herbal supplements that you are currently taking. _____

_____

What is your greatest health concerned at the present time for which you are seeking nutritional and lifestyle counseling? _____

_____

_____

How willing are you to make changes in your diet and lifestyle? (1) maybe (2) average (3) willing (4) very willing

Section 3: Past Health Problems & Lifestyle Habits *(continued)*

In this section, please try to respond accurately to the questions. Circle either Yes or No as they apply to you. Fill in the blanks if you response affirmatively to any question.

Past Health History:

Have you ever had a broken bone?	No Yes which? _____
Have you had any operations?	No Yes what? _____
Have you had any recent weight loss?	No Yes how many pounds? ____ reason?
Have you had any recent weight gain?	No Yes how many pounds? ____ reason?
Do you have any missing limbs?	No Yes which? _____
Do you have any paralysis in any limb?	No Yes which? _____
Does your head tilt to one side?	No Yes
Have you ever passed out?	No Yes please describe: _____
Have you ever been knocked unconscious?	No Yes please describe: _____
Do you have any cavities/fillings in your teeth?	No Yes approximately how many?___
Do you have any teeth missing?	No Yes

FEMALE ONLY:

Are you pregnant now?	No Yes for how many years? _____
Do you currently take birth control pills?	No Yes for how long? _____ when did you quit?
Have you done so in the past?	____
Have you ever had a previous miscarriage?	No Yes
Have you ever had a previous abortion?	No Yes
How many successful pregnancies have you had?	_____
Are you still menstruating regularly?	No Yes if no, age when stopped:_____ why?
No Yes Maybe if yes, how many months? _____	_____

NATURAL LAWS OF HEALTH

Fill in the space provided or put an "X" in the blank next to the appropriate answer.

Nutrition

How often do you drink a glass of milk? _____ times/week. What kind of milk do you use?_____
How often do you eat a tossed green leafy salad? _____ times/week.
How often do you eat steamed or cooked vegetables? *(e.g. kale, collards, broccoli, carrots, etc.)*____times/week..
How often do you eat fruits? _____ times/week. Which fruits do you eat most often?_____
How often do you eat soup or stew? _____ times/week.
Which soups do you eat most often? (not brand names) _____
How often do you eat meat (fish, seafood, chicken, turkey, beef, pork)? _____times/week.
What kind of meats do you eat most often? _____
How often do you eat nuts or nut butter? _____times/day-week My favorite nut/butter is _____
How often do you eat hot spicy foods? _____ times/week.
List the foods that you use most often as between meal snacks. _____
What time do you eat your largest meal of the day? _____ am/pm.
How often do you eat breakfast? Daily____ Seldom____ Never____
What time do you have your last meal of the day? _____ pm. Are you exhausted at mealtime Yes ____ No____
How often do you use salt? ____ times/day-week

Godly Trust

Are there lots of negative stresses in you life? No Yes; If yes circle one: least 1 2 3 4 5 6 7 8 9 10 greatest stress
How often do you have bible reading/devotion? ____ x/day/week OR ___ hours ____ x/day/week
Are you stressed, tensed, or angry at mealtime? Yes___ No___ How often? Sometimes__ always___ Never____
Which one cause the greatest stress in your life? Family___, Health___, Work___, Church___, Finance___

Open Air

How much time do you spend indoor each day? _____ hours; almost all day____
Does fresh air to circulate inside your home daily? Yes____ No____

Daily Exercise

Do you exercise regularly? Yes___ No___ What type? _____
What time of the day do you exercise? _____ How often? _____ x/day/week/month.
Do you perspire (sweat) during your exercise routine? Yes____ No____ Most of the time___ Always___ Sometimes_____
How much time do you spend sitting each day? _____ hours; most of the time___; always sitting____

Plenty of Water

How many glasses of water do you drink daily? _____ How many ounces per day?_____
How much liquid do you drink with meals? _____ ounces; Which liquid? _____ Hot___ /cold____?
What is the color of your urine most times? Pale ____; Yellow ____; Orange ___; Other _____
Which beverage do you drink most often? _____ How many ounces? _____

Lots of Rest

What time do you go to bed at nights? _____pm. Do you rest during the day? Yes_____ No___
How many hours of sleep do you get each night? _____ hours *Note*_____
Are you unable to sleep at some point during the night? Yes___ No___. What time of the night? _____

Always Temperate

Do you use any alcoholic beverages? No___ Yes___ which? _____ how often? _____
How often do you eat chocolate? _____times/week.
How often do you drink brewed or iced tea, Lipton's tea, Nestea? _____times/week.
Did you ever take any drugs? No___ Yes____ Which?_____
When did you quit? _____
Do you smoke? No___ Yes___ if so, how many packs per day? ___ How long?__ _
if No, did you ever smoke? No___ Yes___ How long ago did you quit? _____
Do you drink coffee? No___ Yes____ if so, how many cups?_____
How many bowel movements do you have per day/week? _____ Do you use laxatives? Yes___ or No____

Sunshine

How much sunshine do you get each day? _____ min/hour or Lots____ None____
Do you allow sunshine in your home? Yes__ No___ Sometimes, Never___, Always___ Most of the time__
Do you avoid exposing yourself to sunlight? Yes ___ No_____

Additional comments that may be helpful

_____

_____

_____

_____

Food Diary

Make a list of the foods and beverages that you drank for the past five days or that best represent your dietary intake. Be sure to list the approximate time that the foods and beverages are consumed. Use the categories below.

TIME	DESCRIPTION	FOODS	BEVERAGE
	SNACK		
	BREAKFAST		
	SNACK		
	LUNCH		
	SNACK		
	DINNER		
	SNACK		