Healthy ON THE Fly

Intake Questionnaire Date _____

Last Name _____ First Name _____

Address _____

_____

City _____ Province/ State _____ Postal Code_____

Phone number: (H)_____ (C)_____(W)_____

Email _____

Date Of Birth_____ Age _____ Martial Status_____

Height _____ Weight _____

Occupation_____ Hours per Week _____

Referred by _____

Family History

List paternal family illnesses

_____

_____

_____

List maternal family illnesses

_____

_____

_____

Personal Health History

Have you been diagnosed, past or present, with any illness or disease? If so please specify

_____

_____

Have you ever been hospitalized or had surgery? When and why?

_____

_____

Have you ever taken antibiotics? _____ When? _____

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Have you ever taken birth control? _____ When?_____

Have you ever been on hormone replacement therapy? _____ When? _____

List all supplements- vitamins, herbs, minerals

_____

_____

List all prescription medication you are taking and why you are taking it:

_____

_____

Describe any health issues/concerns you are currently experiencing.

_____

_____

_____

_____

Do you experience digestive difficulties (i.e.: bloating constipation, gas, constipation)?

_____

_____

_____

How often do you have a bowel movement? _____

Do you strain to have a bowel movement? _____ Are bowels loose? _____

Do you take laxatives? _____ How often? _____ What kind? _____

List any food or environmental allergies you experience

_____

_____

Do you avoid these foods? _____

Diet

How much water do you drink daily? _____

Do you consume coffee? _____ How much, how often? _____

Do you consume tea? _____ How much, how often? _____

Do you consume alcohol? _____ How much, how often? _____

Other Drinks _____

Do you eat meat? _____ How many times a week? _____

What is/are your favourite food(s)?

_____

What foods do you avoid?

_____

Do you experience any symptoms after meals?

_____

Do you experience any symptoms if meals are missed?

_____

Describe your relationship with food. Please be very specific.

_____

_____

_____

Lifestyle

How many hours do you sleep a night? _____

Do you have trouble falling asleep? _____ Staying asleep? _____

Do you wake frequently during the night? _____

Do you wake feeling rested? _____

Do you exercise? _____ How often? _____

List type of exercise _____

What do you do to have fun?

_____

_____

How do you express your creativity?

_____

_____

Do you have any pets? _____

What level of stress are you currently experiencing? _____

Please list main stressors:

_____

_____

Please provide any other information that may be relevant but hasn't been covered in regard to emotions

_____

_____

Do you use a computer? _____ How many hours/ day? _____
Do you use a cell phone? _____ How many hours/ day? _____
Do you watch TV? _____ How many hours/ day? _____

Chemicals
Where did you live growing up- city or country? _____
What type of environment do you/ have you work(ed) in? _____
How many cigarettes do you smoke per day? _____
For how many years? _____ If you quit, how long ago?_____
Do you or have you now or have you used recreational drugs? _____
Have you had any dental work done? Do you have fillings (metal), root canals, crowns, etc?

_____

_____

Do you use antacids? _____
Are you now, or have you ever, taken birth control pills? _____ When? _____
Are you now or have you ever been on hormone replacement therapy?

_____

Have you ever had shots/vaccinations (including flu shots)? Which ones?

_____

_____

Is there anything that will get in the way of following a treatment plan in order to achieve results? _____
On a scale of 1- 10 (1 being the lowest and 10 being the highest), what is your level of commitment to improving your health? _____

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