Name:_____Date:_____

Lifestyle Questionnaire

(Please complete both sides)

Primary
Complaint:_____

How long have you had these symptoms? _____

Is this the first time you have experienced this problem? ☐ Yes ☐ No

If no, please describe any treatment you may have previously received for this problem.

_____

_____

Are you still receiving treatment? ☐ Yes ☐ No

Are you under a Doctor's care for any other condition(s)? ☐ Yes ☐ No

If yes, please describe (include Doctor's name, condition(s) and type(s) of treatment:

_____

_____

_____

Please list all prescription medications and supplements you are currently taking:

Please list all vitamins & are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

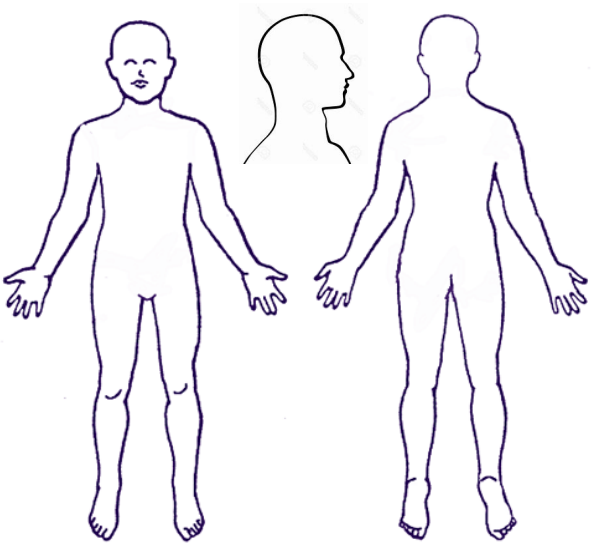
_____ _____

Have you ever had any serious falls or strains? ☐ Yes ☐ No (If yes, please explain)

_____

_____

Indicate on the figure below where you are experiencing pain or discomfort:



Check all that apply:

- ☐ Joint Stiffness
- ☐ Arthritic Tendencies
- ☐ Extremities cold, clammy
- ☐ Hands and feet go to sleep easily
- ☐ Leg nervousness at night
- ☐ Neck pain or stiffness
- ☐ Bruise easily
- ☐ Loss of energy Depression
- ☐ Headaches
- ☐ Blood pressure problem
- ☐ Heart Problems
- ☐ Indigestion soon after meal
- ☐ Constipation

- ☐ Susceptible to colds and fevers
- ☐ Respiratory disorders Allergies
- ☐ Difficulty Sleeping
- ☐ Irritable and restless
- ☐ Hungry between meals

- ☐ Eat out two or more times a week
- ☐ Crave Salt
- ☐ Milk products cause distress
- ☐ Eat when nervous
- ☐ Stress
- ☐ Dizziness
- ☐ Diabetes
- ☐ Difficulty swallowing

Rank the following from 1 to 4: 1 – none; 2 – light; 3 - moderate; 4 - heavy

_____ Alcohol
_____ Coffee
_____ Drugs
_____ Tobacco
____ Exercise
_____ Soft Drinks

Approximately how many glasses of water do you drink per day? _____(8oz. glasses).