

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  
supplements you  
you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all vitamins &  
are currently taking:

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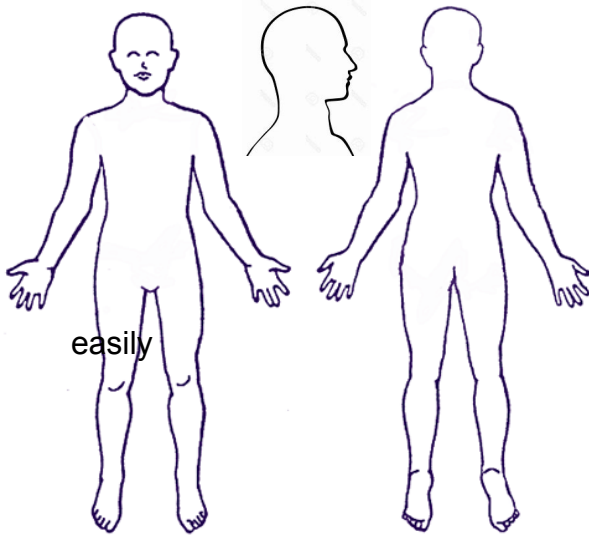
Have you ever had any serious falls or strains?  Yes  No (If yes, please explain)

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



Check all that apply:

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

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

Eat out two or more times a week

Stress

Crave Salt

Dizziness

Milk products cause distress

Diabetes

Eat when nervous

Difficulty swallowing

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

\_\_\_\_\_ Alcohol

\_\_\_\_\_ Tobacco

\_\_\_\_\_ Coffee

\_\_\_\_\_ Drugs

\_\_\_\_\_ Exercise

\_\_\_\_\_ Soft

Drinks

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