REBECCASNOW

Health Questionnaire

Name: _____ Today's Date: _____

Address: _____ City and State: _____ Zip: _____

Email: _____ Skype Contact (if applicable): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Which numbers are best for leaving detailed messages? _____ What is your preferred method of contact? _____

How did you find out about Rebecca Snow? _____ Would you like to receive news and recipes from Rebecca Snow? _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Place of Birth: _____

Genetic Background: ☐ African-American ☐ Native-American ☐ Mediterranean ☐ Asian ☐ Northern European ☐ Caucasian ☐ Other: _____

What would you like help with at this time?

_____

Please list your health concerns:	**How long have you had these conditions?**

Name and contact info for Primary Physician: _____

Please list any other practitioners that you are seeing: _____

Relationship	Alive/Deceased	Present Health Status or Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brothers		
Sisters		
Children		

Comments on family health history: _____

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

	Name	Dosage	Frequency	Length of time	Purpose
Medications					

	Name	Dosage	Frequency	Length of time	Purpose
Supplements					

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

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

Physical Activity and Lifestyle

What kind of physical activities do you do? _____

Are you satisfied with your energy level? _____

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

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

What do you do for relaxation? _____

How many hours of sleep do you get a night/day? _____ Do you sleep well? _____

Relationship status: _____ # of times married: _____ Divorced: _____ Widowed: _____

Current Occupation: _____ How Many Years? _____ Hours per week? _____ Do you like your work? _____

Passions and Interests: _____

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

Work: _____ Social/family situation: _____

Current health status: _____ Life in general: _____

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

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Environmental information: How often are you exposed to any of the following? *Insert a number and select **day** or **week***

Cigarette smoke _____ times per: ☐ day ☐ week	How many mercury amalgams do you have? _____
Wood stove _____ times per: ☐ day ☐ week	Recreational drugs _____ times per: ☐ day ☐ week
Perfumes/hair dyes _____ times per: ☐ day ☐ week	Pet dander _____ times per: ☐ day ☐ week
Car exhaust _____ times per: ☐ day ☐ week	Mold _____ times per: ☐ day ☐ week
Pesticides _____ times per: ☐ day ☐ week	Cleaning products _____ times per: ☐ day ☐ week
Dry cleaned clothes _____ times per: ☐ day ☐ week	Teflon or aluminum pans _____ times per: ☐ day ☐ week
Photo developing/ harsh chemicals _____ times per: ☐ day ☐ week	Bottled water _____ times per: ☐ day ☐ week

Nutrition

Have you ever had a nutritional consult? _____

Please list **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 grocery shop? _____

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

How would you describe your relationship to food? _____

Height: _____ Weight: _____ Ideal weight: _____

Highest adult weight: _____ Year: _____ Lowest adult weight: _____ Year: _____

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Food Frequency: How often do you eat or do the following? *Insert a number and select **day** or **week***

Meals per day: _____	Red Meat _____ times per: ☐ day ☐ week
Snacks per day: _____	Chicken/Turkey _____ times per: ☐ day ☐ week
Water _____ ounces per day	Deli Meat _____ times per: ☐ day ☐ week
Prepare meals _____ times per: ☐ day ☐ week	Fish _____ times per: ☐ day ☐ week
Nuts/Seeds _____ times per: ☐ day ☐ week	Shellfish _____ times per: ☐ day ☐ week
Lentils/Beans _____ times per: ☐ day ☐ week	Organ meat _____ times per: ☐ day ☐ week
Yogurt _____ times per: ☐ day ☐ week	Soy products _____ times per: ☐ day ☐ week
Bread _____ times per: ☐ day ☐ week	Eggs _____ times per: ☐ day ☐ week
Dairy Milk/Cheese _____ times per: ☐ day ☐ week	ALL VEGGIES: _____ times per: ☐ day ☐ week
Other Milk _____ times per: ☐ day ☐ week	ALL FRUIT _____ times per: ☐ day ☐ week
Fats and oils _____ times per: ☐ day ☐ week *What kinds?* _____	Coffee _____ times per: ☐ day ☐ week *Decaf or Regular?* _____
Whole Grains _____ times per: ☐ day ☐ week	Herbal or other Tea _____ times per: ☐ day ☐ week
Pasta _____ times per: ☐ day ☐ week	Soft Drinks _____ times per: ☐ day ☐ week *Diet or Regular?* _____
Chips/crackers etc. _____ times per: ☐ day ☐ week	Frozen Dinners _____ times per: ☐ day ☐ week
Candy _____ times per: ☐ day ☐ week	Alcoholic Drinks _____ times per: ☐ day ☐ week
Fast Food: _____ times per: ☐ day ☐ week	Eat fast or on the run _____ times per: ☐ day ☐ week

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	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack
Dinner	Dinner	Dinner
Snack	Snack	Snack

Symptom Review: Please **mark with an "X"** any symptoms noticed in the past year. For any major symptoms that you had previously, but no longer have, **mark with a "P"**

UPPER GI

_____ Sometimes nausea in evenings
_____ Indigestion after eating
_____ Duodenal ulcer
_____ Sometimes foul burps
_____ Butterflies in stomach
_____ Seldom eat breakfast
_____ Often don't finish meals
_____ Often eat to calm down
_____ Frequent use of alcohol

_____ Frequent poor appetite
_____ Bitter taste or bad breath in morning
_____ Acid indigestion at night
_____ Frequent mouth or cold sores, or receding gums
_____ Mouth frequently too dry, or difficulty swallowing
_____ Sometimes nausea in mornings
_____ Sometimes excess salivation
_____ Stomach ulcer
_____ Strong, demanding hunger

LOWER GI

_____ Tongue often coated
_____ Frequent constipation, need for laxatives
_____ Light colored, hard stools
_____ Intestines often bloated, or gassy
_____ Constipation with hemorrhoids or pain
_____ Constipation with hard, marbly stools

_____ Alternating constipation / diarrhea
_____ Stools loose with gas
_____ Digestion unusually rapid
_____ Loose stools when tired/stressed
_____ Dark, soft stools
_____ Quick defecation after eating

LIVER

_____ Dry, even scaly skin
_____ Hay fever or asthma
_____ Craves fruit or sweet
_____ Frequent trouble digesting fats
_____ Acne on face AND buttocks
_____ Seem to have low blood sugar
_____ Had hepatitis in past

_____ Frequent use of alcohol or chemicals/solvents
_____ Psoriasis, eczema, dermatitis
_____ Frequent minor illnesses, don't sweat
_____ Moist, sometimes oily skin
_____ Hives from food or drugs
_____ Craves protein, fats
_____ Fever with sweat when sick

RENAL & URINARY

_____ Standing quickly causes faintness or dizziness

_____ Frequent flushing or blushing

_____ Moderate low blood pressure

_____ Frequent thirst

_____ Craving for salt

_____ Urine always light colored

_____ Dull ache or dribble after urination

_____ Frequent bladder infections

_____ Frequent or urgent urination, small amounts

_____ Mucus in urine

_____ Standing quickly makes pulse roar in ears

_____ Frequent water retention

_____ Urine usually dark

_____ Moderate high blood pressure

_____ Infrequent urination, copious urine

MALE REPRODUCTIVE

_____ Difficult maintaining erection when you feel in the mood

_____ Benign prostatic hypertrophy

_____ Pain or ache after orgasm

Are you sexually active? _____

FEMALE REPRODUCTIVE

_____ Cycle more than 28 days

_____ Miss some periods

_____ Menses slow starting with cramps

_____ Menstruation always lengthy

_____ Abnormal Pap Smear

_____ History of PID, cervicitis

_____ Miscarriages, problem pregnancy

_____ Tried, couldn't take birth control pills

_____ 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

_____ **Number of Children/Live Births**

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

Date of Last Menses _____

Are you sexually active? _____

Birth Control Method _____

RESPIRATORY

_____ 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 & SKIN

_____ Dry scalp or hair

_____ Lips often dry and chapped

_____ Sores, cracks, fissures in mouth, vagina or anus

_____ Food causes distress as it passes through

_____ Skin eruptions are deep, not coming to a head

_____ Cracks, fissures on heel, elbow, feet, poorly healing

_____ Oily scalp or hair

_____ Sweat freely with strong scent

_____ Oily skin, facial acne

Symptom Review (continued): Please **mark with a "1"** if a symptom somewhat applies. **Mark with a "2"** if a symptom strongly applies.

GENERAL

_____ 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

_____ 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

GENERAL	
_____ Depressed for long periods	_____ Sensitive to cold weather
_____ Earaches	_____ Sensitive to hot weather
_____ Eats often or else faint/nervous	_____ Sensitive to high humidity
_____ Eyes often red or inflamed	_____ Sensitive to low humidity
_____ Face, eyes get puffy	_____ Sexual desire decreased
_____ Facial twitches	_____ Sexual desire increased
_____ Gum problems	_____ Stuffy nose during day
_____ Headaches	_____ Stuffy nose in evening or night
_____ Headaches in morning, wearing off	_____ Tendency to anemia
_____ Heart palpitations after eating	_____ Tremors in hands or neck
_____ Highly emotional	_____ Varicose veins
_____ Highly controlled	_____ Weight gain in upper arms, shoulders, back of neck
_____ Impaired hearing	