

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
- ___ awoken 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

- ___ 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

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 _____

Do any of these foods upset you?

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

Male only

- ___ prostrate trouble
- ___ lumps in testicle
- ___ diminished sexual activity
- ___ swollen testicles
- ___ difficulty urinating

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 concern 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? _____

Lifestyle Habits

How many bowel movements do you have per day/week? _____ Do you use laxatives? Yes or No
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 exercise regularly? No Yes What type? _____ how often? _____
What time do you go to bed at nights? _____ P.M. Do you rest during the day? Yes No
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 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 or cold?
What is the color of your urine most times? Pale _____; Yellow _____; Orange _____; Other _____
Do you drink coffee? No Yes if so, how many cups? _____
Do you use any alcoholic beverages? No Yes which? _____ how often? _____
Which beverage do you drink most often? _____ How many ounces? _____
Is your largest meal at noontime? No Yes
How often do you eat breakfast? Daily Seldom Never
What time do you have your last meal of the day? _____
How much time do you spend indoor each day? _____ hours/ almost all day
Did you ever take any drugs? No Yes which? _____
when did you quit? _____

Section 4: Dietary Habits

Fill in the blanks provided.

- 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. mustard, kale, collards, broccoli, carrots, etc.) ___x/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? _____
- How often do you eat hot spicy foods? _____ times/week.
- How often do you eat chocolate? _____ times/week.
- How often do you use salt? _____
- How often do you drink brewed or iced tea, Lipton's tea, Nestea? _____ times/week.

Food Diary

Make a list of the foods and drinks that you ate during the past 8 days. Use the categories given below.

Time	Beverages
<u>Breakfast:</u>	
<u>Snacks:</u>	
<u>Lunch:</u>	
<u>Snacks:</u>	
<u>Dinner:</u>	

Make Check or Money order payable to **C.H.E.M.** P.O. Box 853 Camden, TN 38320

Response Time: **within 2 weeks**