HEALTH QUESTIONNAIRE

Name ______________________ Age ________ Date ______________

1. Do you currently take a multi-vitamin? ______ Yes ______ No
2. Do you know your blood type ___ A ___ AB ___ B ___ O ___ Don't Know
3. Do you take any supplements? (*please check all that apply*)

_____	Vitamin C	_____	B-Complex	____	CoEnzyme Q10	____	Magnesium
_____	Vitamin D	_____	Glucosamine	____	Beta Carotene	____	Chromium
_____	Vitamin E	_____	Garlic	____	Calcium	____	DHEA
_____	L-Carnitine	_____	Ginkgo Biloba	____	Saw Palmetto	____	Fiber
_____	Melatonin	_____	Flax Oil	____	Fish Oil	____	Other

4. Do you take any prescription drugs?
   If so, please list: ______________________________

____

____

5. Are you allergic to any medications, foods, or environmental factors that you know of?

____

6. Which areas of health are a concern to you? (*check all that apply, circle your most pressing issue*)

General Conditions
- _____ Allergies
- _____ Asthma
- _____ Back Pain
- _____ Bladder Dysfunction
- _____ Anxiety / Stress / Depression
- _____ Low Energy / Fibromyalgia
- _____ Ear / Hearing Problems
- _____ Kidney Problems or Stones
- _____ Migraine Headaches
- _____ Skin Conditions
- _____ Thyroid
- _____ Weight Control
- _____ Memory Loss
- _____ Hormones
- _____ Autoimmune

Heart Disease
- _____ Angina
- _____ Cholesterol
- _____ Coronary Artery Disease
- _____ High Blood Pressure

Digestion
- _____ Constipation
- _____ Gas
- _____ Heartburn / Indigestion
- _____ Ulcers

Vision Care
- _____ Cataracts
- _____ Macular Degeneration
- _____ Glaucoma

Women's Health
- _____ Breast Cancer
- _____ Hormone Replacement
- _____ Hot Flashes
- _____ Menopause
- _____ Osteoporosis
- _____ Heavy/Irregular Periods

Men's Health
- _____ Prostate
- _____ Impotence

Degenerative Diseases
- _____ Alzheimer's Disease
- _____ Arthritis
- _____ Diabetes
- _____ Other______________

6. Who else lives in your home? (*please check all that apply*)
   ____ No Others ____ Spouse / Significant Other ______ Children
7. Have you recently painted or remodeled? ____Yes _____No
8. Water System Well____ City ____ or other, what kind? ______________
9. Do you have pets? ____ Yes ____ No If yes, what kind? ______________________
10. Are you in a house that was built within ______ 1-5 yrs ______ 6-15 yrs ______ 16-25 yrs
11. What type of flooring is in your home? _____ Synthetic _____ Natural _____ How old?
12. Do you use lawn chemicals? ______ Yes ______ No