Integrative Health & Wellness Questionnaire

GENERAL INFORMATION

Name _____ Gender: M F Today's date / /

E-Mail Address _____ Height _____ Weight _____ BMI _____

Street Address City ST Zip

Phone #: Home Work Cell Marital Status: S M D W Sep

Date of Birth / / Allergies: Do you smoke (PPD)? _____-

Occupation Employer

Living Situation: ❑Alone ❑Friend(s) ❑Partner ❑Spouse ❑Parents ❑Children #of children: _____ ❑Pets

Physician #1 Physician #3

Physician #2 Other Holistic Care Provider(s)

DIAGNOSTIC HISTORY (Include DATES if known): Total cholesterol _____, LDL cholesterol _____, HDL cholesterol _____blood levels, vitamin D blood level _____, Dexascan T/Z score_____, fasting blood sugar level _____, HA1C _____, blood pressure reading _____, T3 _____, T4 _____, TSH _____blood levels (thyroid), PSA level (men) _____, Myers Briggs Personality Type_____, DISC Type _____, Strengths Finder Leadership Style _____, Enneagram Personality Type _____

PAST MEDICAL HISTORY

PAST SURGICAL HISTORY

AREAS OF PAIN OR DISCOMFORT

❑ Head ❑ Neck ❑ Shoulders ❑ Arms or Legs ❑ Back ❑ Hips ❑ Knees ❑ Other _____

MEDICATIONS Please list any prescription or OTC medications you are regularly taking. Please use a separate piece of paper for this complete list, preferably typewritten. Include any use of medical marijuana or CBD oil (hemp products).

DIETARY SUPPLEMENTS Please list all dietary supplements including BRAND NAMES and MANUFACTURERS (herbs, vitamins, protein powders). Please use a separate piece of paper for this complete list, preferably typewritten.

Water/Caffeine/Alcohol (amount/frequency)?

SOCIAL HEALTH How would you describe your social support system?

NUTRITION Are there any significant gaps in your nutritional regimen (e.g., protein, colorful fruits & vegetables, oily fish like salmon/tuna/sardines)? Please list. What is your relationship with food (e.g., healthy Mediterranean Diet, emotional eater, carb snacker, pizza lover)?

SLEEP HEALTH Describe any problems with falling asleep or staying asleep? How often?

EXERCISE How and when do you exercise?

STRESS & RELAXATION Please list any areas (sources) of stress in your personal or work life and your coping practices.

EMOTIONAL HEALTH Any pivotal emotional events in your life?

How do you typically spend your day (e.g., where is most of your energy spent)?

What do you do to relax (hobbies, meditate, read, garden, music, art, golf, bike)?

SPIRITUAL HEALTH Do you have any spiritual concerns, fears?

Do you have a faith community (yes/no; denomination)?

How much time do you like to spend in nature each week?

HEALTH GOALS What are your most important personal goals for your health and wellness? What is your primary reason for today's visit?