HEALTH EVALUATION FORM

The following questionnaire is a comprehensive look at your health. It will take about 5 minutes to complete

Health ID :

Full Name

Gender

- Male
- Female

E-mail

Phone Number

Area code | 10 digit number

GENERAL INFORMATION

Name of Doctor or other health professionals you are currently seeing

Date of Birth

Day | Month | Year

Height if known

Cm

Weight if known

Kgs

What are the main reasons you are seeking health care? *

- [ ] Weight loss
- [ ] Detox
- [ ] Disease Prevention
- [ ] Pre-conception & Pregnancy Care
- [ ] Digestive Support
- [ ] Cardiovascular Protection
- [ ] Stress Management
- [ ] Dietary Advice
- [ ] Energy
- [ ] Immune System
- [ ] Sports Enhancement
- [ ] Pain Management
- [ ] Other

The following three questions: 1 - 10 (1=poor / 10=excellent)

	1	2	3	4	5	6	7	8	9	10	
How do you rate your current level of health *	Worst	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	Best
How do you rate your current level of energy or vitality *	Worst	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	Best
How do you rate your current stress levels *	Worst	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	Best

How many hours sleep do you get a night? *

Do you have trouble getting to sleep? *

- ◯ Yes
- ◯ No

Do you wake often, or get woken easily? *

- ◯ Yes
- ◯ No

Do you have to go to the bathroom during the night? *

- ◯ Yes
- ◯ No

Do you snore or have breathing problems during sleep? *

- ◯ Yes
- ◯ No

Please list any known allergies *

Please list any medications you are currently taking (e.g. warfarin, contraceptives, laxatives)

Please list any supplements you are currently taking

Do you have a main health complaint? Please describe.

Are there any of the following medical conditions in your family history that you are aware of? Please tick all that apply.

- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorders (e.g. lupus, rheumatoid arthritis)
- ☐ Bowel Disorders
- ☐ Cancer
- ☐ Dementia / Alzeihmers
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Low Blood Pressure
- ☐ Mental Illness
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Osteoporosis
- ☐ Skin Disorders
- ☐ Strokes
- ☐ Thyroid Over Active
- ☐ Thyroid Under Active
- ☐ Other

Next: Diet and lifestyle . .

Do you exercise? *

- ◯ Never
- ◯ 1-2 times a week
- ◯ 3-4 times a week
- ◯ 5-6 times a week
- ◯ Everyday

Please list the types of exercise you do regularly

Do you smoke? *

- ◯ Yes
- ◯ No

How many per wk?

Do you take recreational drugs? *

- ◯ Yes
- ◯ No

Please list any food allergies / intolerances that you are aware of?

How many glasses of water do you have a day? *

Do you drink alcohol?

- ◯ Yes
- ◯ No

How many per week? *

Patient health history

Frequency of exercise (days per week): *

- ◯ 6 - 7
- ◯ 3 - 5
- ◯ 1 - 2
- ◯ 0

Vegetarian or vegen: *

◯ Yes ◯ No

Age >50 years: *

◯ Yes ◯ No

Planning to have a baby in the next 3-6 months: *

◯ Yes ◯ No

Pregnant or breastfeeding: *

◯ Yes ◯ No

Do you diet often? *

◯ Yes ◯ No

Are you unhappy with your weight?: *

◯ Yes ◯ No

Do you have a family history of diabetes, cardiovascular disease, cancer, or any other major illness?: *

Would you like us to E-mail you a copy of your HAQ? *

◯ Yes ◯ No

Your Preferred E-mail Address *