PATIENT WELLNESS QUESTIONNAIRE

HEALTHY TOUCH
WHOLE HEALTH CARE, INC.
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NAME	SPOUSE'S NAME	TODAYS DATE

WEIGHT	DATE OF BIRTH	AGE	☐ RIGHT HANDED ☐ LEFT HANDED	SIBLING ORDER

ADDRESS

PHONE NUMBERS: BEEPER ....
HOME .... FAX ....
OFFICE .... CELL ....

MARITAL STATUS	YEARS	CHILDREN'S NAMES, SEX & AGES

REFERRED BY	EMERGENCY NAME AND NO.

LIST 5 MAJOR HEALTH CONCERNS IN YOUR ORDER OF IMPORTANCE:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

SPIRITUAL LIFE
I believe that God is the healer and that spiritual healing is necessary for physical and emotional healing to take place.

SPIRITUAL BELIEFS

SPIRITUAL ACTIVITIES
CHURCH ____________________
HOW LONG ATTENDED ____________________
PASTOR ____________________
OTHER ____________________

CHURCH ACTIVITIES

DAILY DEVOTION / MEDITATION

EMOTIONS: EMOTIONS THAT I COMMONLY EXPERIENCE (CHECK ALL THAT APPLY):
☐ Joy ☐ Peace ☐ Happiness ☐ Contentment ☐ Love ☐ Fulfillment ☐ Safety ☐ Satisfaction ☐ Other ________
☐ Anger ☐ Fear ☐ Resentment ☐ Bitterness ☐ Jealousy ☐ Heartbreak ☐ Sadness ☐ Loss ☐ Depression
☐ Overwhelm ☐ Anxiety ☐ Rejection ☐ Abandonment ☐ Other ________

HOME STRESS LEVEL PLEASE CIRCLE: (LEAST) 0 1 2 3 4 5 6 7 8 9 10 (MOST)

EDUCATION	INSTITUTION	DEGREES / CERTIFICATES

OCCUPATION:	HOW LONG IN THIS FIELD?
EMPLOYED BY:	HOW LONG WITH THIS EMPLOYER?

LIST WORK YOU HAVE DONE WHERE YOU WERE EXPOSED TO TOXIC CHEMICALS, RADIATION, ETC. AND WHAT TYPE OF TOXINS?

DO YOU SPRAY YOU HOUSE WITH INSECTICIDES OR PESTICIDES? ________
TIMES/YEAR ________ FOR HOW MANY YEARS? ________

JOB STRESS LEVEL PLEASE CIRCLE (LEAST) 0 1 2 3 4 5 6 7 8 9 10 (MOST)

JOB FULFILLMENT LEVEL PLEASE CIRCLE (LEAST) 0 1 2 3 4 5 6 7 8 9 10 (MOST)

HAVE YOU RECEIVED ☐ REFLEXOLOGY ☐ MASSAGE ☐ ACUPRESSURE ☐ ACUPUNCTURE ☐ COUNSELING ☐ CHIROPRACTIC ☐ HERBS AND/OR NUTRITIONAL SUPPLEMENTS? BY WHOM, AND WHEN?

LIST OTHER COMPLEMENTARY HEALTH THERAPIES THAT YOU RECEIVE(D).

ARE YOU PRESENTLY UNDER THE CARE OF: ☐ MEDICAL DOCTOR ☐ SURGEON ☐ CHIROPRACTOR ☐ OSTEOPATH ☐ NATUROPATH ☐ ACUPUNCTURIST ☐ OTHER DOCTORS NAME(S)

FOR WHAT CONDITION(S): | FOR HOW LONG? | ARE YOU TAKING MEDICATION?

MEDICATION | DATE BEGUN | ACTION OF MEDICATION | DOSAGE

HAVE YOU TAKEN: ☐ STEROIDS ☐ BIRTH CONTROL PILLS | HOW LONG?

HOW MANY TIMES PER YEAR DO YOU TAKE ANTIBIOTICS? | NAME OF THE ANTIBIOTIC(S)

PAST MEDICATIONS | CHILDHOOD ILLNESSES (AGE)

PAST ILLNESSES OR CONDITIONS: | PRESENT ILLNESSES OR CONDITIONS:

PARENTS' OR FAMILY ILLNESSES: | MOTHER'S SIDE | FATHER'S SIDE

INJURIES: (DATES) | AUTO ACCIDENTS (DATES) | SURGERIES: (DATES)

ALLERGIES | ARE YOU TAKING NUTRITIONAL SUPPLEMENTS ☐ YES ☐ NO

SUPPLEMENTS | DOSAGE | FOR WHAT PURPOSE

ARE YOU PREGNANT? ☐ YES ☐ NO HOW MANY MONTHS?

☐ MENOPAUSE ☐ MENSTRUATION? REGULAR? ☐ YES ☐ NO IF NO, DESCRIBE

DESCRIBE A TYPICAL:

BREAKFAST	LUNCH	DINNER	SNACK

VEGETABLES PER DAY	FRUITS PER DAY	WHOLE GRAINS PER DAY
MEATS PER DAY	DAIRY PER DAY	SWEETS: *IN WHAT FORM?

DO YOU EAT LUNCHMEAT? ☐ WHAT KIND? ____________________

**(Consuming sugar can cause fuingus to grow in our bodies. Fungus weakens our organ systems. How much, and what type of sugar - cookies, cakes, candy bar, fruit juice, candy, etc. - do you consume on a daily or weekly basis?*

DO YOU USE: ☐ EQUAL, NUTRASWEET, ASPERTAME ☐ SPLENDA ☐ XYLITOL ☐ STEVIA HOW MUCH PER DAY? ________

RATE YOUR ENERGY LEVEL IN THE MORNING PLEASE CIRCLE: (LEAST) 0 1 2 3 4 5 6 7 8 9 10 (MOST)

RATE YOUR ENERGY LEVEL IN THE AFTERNOON PLEASE CIRCLE: (LEAST) 0 1 2 3 4 5 6 7 8 9 10 (MOST)

RATE YOUR ENERGY LEVEL IN THE EVENING. PLEASE CIRCLE: (LEAST) 0 1 2 3 4 5 6 7 8 9 10 (MOST)

HOW MANY OUNCES OF PLAIN WATER DO YOU DRINK DAILY? ______ ☐ BOTTLED ☐ FILTERED ☐ WELL ☐ TAP

COFFEE: _____ CUPS PER DAY ICED TEA: ______ CUPS / GLASSES PER DAY HERB TEA: _____ PER DAY

ALCOHOL: _____ PER DAY TYPE __________ | SOFT DRINKS _______ PER DAY BRAND ________ ☐ REGULAR ☐ DIET

TOBACCO USAGE: ☐ PRESENT ☐ PAST TYPE __________ QUANTITY _______ HOW LONG? _____ DATES __________

HAVE YOU BEEN EXPOSED TO SECOND HAND SMOKE? AGE ________

HAVE YOU TAKEN RECREATIONAL DRUGS? WHAT KIND? ______________ WHEN? ______________

OTHER ADDICTIONS: ______________________________

HOW MANY HOURS PER NIGHT DO YOU SLEEP? ________ SOUNDLY? ________

HOW MANY BOWEL MOVEMENTS DO YOU HAVE PER DAY? ______

DO YOU HAVE SILVER (MERCURY AMALGUM) FILLINGS? ☐ NO ☐ YES HOW MANY? ______

HAVE YOU HAD MERCURY FILLINGS REMOVED? ☐ NO ☐ YES WHEN? __________

CONTACT WITH ANIMALS IN THE PAST OR PRESENT MAY INFECT US WITH PARASITES. DO YOU PRESENTLY HAVE ANIMALS?
☐ YES ☐ NO LIST NUMBER AND TYPES OF ANIMALS, WEIGHT, AGE, INSIDE OR OUTSIDE

LIST ANIMALS OF THE PAST	DO YOU KISS YOUR PETS? ☐ YES ☐ NO
DO YOU WALK BAREFOOT OUTSIDE? ☐ YES ☐ NO	DO YOU EAT RAW OR RARE COOKED MEATS OR SUSHI? ☐ YES ☐ NO

POSSIBLE SOURCE OF PARASITE INFECTION:
DO YOU EAT FAST FOOD HAMBURGERS? ☐ YES ☐ NO __________ TIMES /MO WHERE? ______________
OTHER FAST FOODS? ☐ YES ☐ NO __________ TIMES /MO WHERE? ______________

DO YOU USE A MICROWAVE OVEN FOR YOUR COOKING? ☐ YES ☐ NO
IF SO HOW MUCH? _______ PER DAY _______ PER WEEK _______ PER MONTH

DO YOU USE PLUG-INS THAT DEODORIZE THE AIR? THEY PUT TOXIC CHEMICALS IN YOUR ENVIRONMENT THAT LEAD TO ALLERGIES.
☐ YES ☐ NO

HOW MANY TIMES PER WEEK DO YOU EXERCISE? _______ | WHAT KIND OF EXERCISE? ______________

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

☐ PHLEBITIS	☐ VARICOSE VEINS	☐ INFECTIOUS SKIN DISEASE
☐ SHINGLES	☐ COLD OR FLU	☐ FEVER
☐ PAIN MEDICATION	☐ NAUSEA	☐ HERNIA
☐ OSTEOPOROSIS	☐ NECK/SPINE INJURY	☐ JOINT INFLAMMATION
☐ HERNIATED DISC	☐ DIABETES	☐ HEART CONDITION
☐ CANCER	☐ INFECTIOUS DISEASE	☐ SEVERE HIGH BLOOD PRESSURE
☐ HERPES OUTBREAK	☐ EPILEPSY	☐ EDEMA FROM KIDNEY, LIVER OR HEART WEAKNESS