General Health Questionnaire

Name, email and best contact phone #:

Birth date, weight and height:

Main Health concern(s)

Blood type (if known): O, A, B, AB

List any current supplements:

List any current medications:

Describe any food cravings:

How much water do you drink per day? What other beverages do you drink per day (type and qty)?

Have you ever smoked cigarettes?

How much sleep do you get each night? Describe sleep pattern, any sleeping problems?

Transit time – how many bowel movements per day? Constipation/diarrhea? Quality of stools?

Women only: Do you use hormonal birth control and if so which one? If not how regular are you? Days between cycles? Do you know when you ovulate? PMS symptoms?

Describe your energy and stress level on a daily basis:

Type and frequency of regular exercise?

Other therapies currently used on a regular basis.

Do you have amalgam fillings (silver) in your mouth? If so how many? Root canals?

Timeline

Developing a Timeline – Add events to each category:
Please for each event include TIMEFRAME and DETAILS

Accidents (incl. falls, broken bones, car accidents, concussions)	
Surgical interventions (any types of surgery incl. dental work)	
Drug Use and/or Hormones	
Birth and Pre-Birth (problems in labor, any drugs, smoking or severe illnesses in mother)	
Severe infections and childhood illnesses (e.g. Lyme disease, Chicken pox, mono, Epstein-Barr)	
Emotional Trauma	
Labor and Delivery	
Other	

Family History

Mother Living? Y/N Serious Illnesses	
M-Grandmother Living? Y/N Serious Illnesses	
M-Grandfather Living? Y/N Serious Illnesses	
Father Living? Y/N Serious Illnesses	
P-Grandmother Living? Y/N Serious Illnesses	
P-Grandfather Living? Y/N Serious Illnesses	
Siblings Living? Y/N Serious Illnesses	
Birth order	