Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lifestyle Questionnaire

(Please complete both sides)

Primary Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this the first time you have experienced this problem? Yes No

If no, please describe any treatment you may have previously received for this problem.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you still receiving treatment? Yes No

Are you under a Doctor’s care for any other condition(s)? Yes No

If yes, please describe (include Doctor’s name, condition(s) and type(s) of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list all prescription medications Please list all vitamins & supplements you

you are currently taking: are currently taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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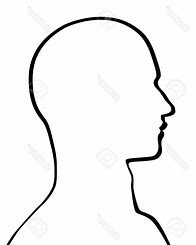
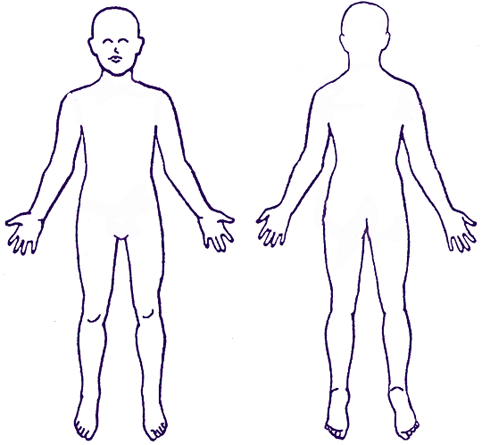
Have you ever had any serious falls or strains? Yes No (If yes, please explain)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Indicate on the figure below where you

are experiencing pain or discomfort:

[](https://www.bing.com/images/search?view=detailV2&ccid=2gEeg1J4&id=011898C1F9D5EEE8C8EFB87667E3EA1089B334E1&thid=OIP.2gEeg1J4Ct19awkAIPqpmgHaJP&mediaurl=https://drawingartistic.com/wp-content/uploads/2017/10/drawing-face-profile-outline-human-head-royalty-free-cliparts-vectors-and-stock-illustration.jpg&exph=1300&expw=1042&q=outline+of+human+profile&simid=607994636566462892&selectedIndex=2) Check all that apply:

Joint Stiffness

Arthritic Tendencies

Extremities cold, clammy

Hands and feet go to sleep easily

Leg nervousness at night

Neck pain or stiffness

Bruise easily

Loss of energy

Susceptible to colds and fevers Depression

Respiratory disorders Headaches

Allergies Blood pressure problem

Difficulty Sleeping Heart Problems

Irritable and restless Indigestion soon after meals

Hungry between meals Constipation

Eat out two or more times a week Stress

Crave Salt Dizziness

Milk products cause distress Diabetes

Eat when nervous Difficulty swallowing

Rank the following from 1 to 4: 1 – none; 2 – light; 3 - moderate; 4 - heavy

\_\_\_\_\_Alcohol \_\_\_\_\_Tobacco \_\_\_\_\_Coffee

\_\_\_\_\_Drugs \_\_\_\_\_Exercise \_\_\_\_\_Soft Drinks

Approximately how many glasses of water do you drink per day? \_\_\_\_\_\_\_\_(8oz. glasses).