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.

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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:

 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).