



**LOVE YOUR BODY PROGRAM HEALTH QUESTIONNAIRE AND ASSESSMENT**

1) Do you consider yourself in good physical health?  YES  NO

2) Are you currently taking any medications?  YES  NO

If yes, what, and for how long? \_\_\_\_\_

3) Do you take vitamin supplements?  YES  NO

If yes, what, and for how long? \_\_\_\_\_

4) Do you have a history at any time in your life or do you currently have any of the following symptoms or body signs?

**Headaches**  YES  NO

If yes, how often? \_\_\_\_\_

Does not eating make them worse? \_\_\_\_\_

What makes them better? \_\_\_\_\_

**Dizziness**  YES  NO

If yes, how often? \_\_\_\_\_

Does it occur bending down or getting out of the a bath quickly? \_\_\_\_\_

From missing a meal? \_\_\_\_\_

**Heart palpitations**  YES  NO

If yes, how often? \_\_\_\_\_

**Kidney or bladder infections**  YES  NO

Circle applicable symptoms: Painful, frequent or burning urination

**Lung or respiratory conditions**  YES  NO

Circle applicable symptoms: Painful inhalation or exhalation, frequent colds, sinusitis, wheezing, shortness of breath, allergies, asthma, none of these?

**Skin conditions**  YES  NO

Circle applicable symptoms: Dry, oily, rashes, acne, hives, boils, eczema, psoriasis, allergic dermatitis

**Digestion conditions**  YES  NO

How often do you have a bowel movement? \_\_\_\_\_

Do you ever have blood with your stools? \_\_\_\_\_

Circle applicable symptoms: Heartburn, burping, bloating, nausea, vomiting, gas or flatulence, diarrhea, constipation, none of these?

- 5) Do you crave any specific foods?  YES  NO  
 If yes, which foods? \_\_\_\_\_
- 6) At any time in the past, or recently, have you consumed a lot of sugar, salt, meat, coffee, or any other food?  YES  NO  
 If yes, how much and which foods? \_\_\_\_\_  
 Are you allergic to any foods? \_\_\_\_\_
- Are there any foods your body doesn't like?  
Circle all that apply; i.e. coffee- hyper, dairy- mucous, sugar- pre-menstrual symptoms or general fatigue, fatty, rich foods- indigestion, etc.?
- 7) Do you exercise regularly?  YES  NO  
 If yes, what do you do, for how long, how many times per week and how long have you been doing this? \_\_\_\_\_  
 \_\_\_\_\_
- 8) Have you ever or do you now drink alcohol more than 1 time per month?  YES  NO  
 If yes, what, how often, how long? \_\_\_\_\_  
 \_\_\_\_\_
- 9) Have you ever or do you now smoke tobacco or cigarettes?  YES  NO  
 If yes, what, how often, how long? \_\_\_\_\_
- 10) What other physical conditions or symptoms have you had recurring Or do you have now?  
 \_\_\_\_\_  
 \_\_\_\_\_
- 11) What diet programs have you done in the past and when? \_\_\_\_\_  
 \_\_\_\_\_  
 What were the results? \_\_\_\_\_  
 Did you have any symptoms? \_\_\_\_\_
- 12) Have you ever been hospitalized for psychiatric care?  YES  NO
- 13) Are you currently in therapy?  YES  NO  
 If yes, please inform your therapist you are doing this program and your therapist must verbally O.K. your participation in this program.
- 14) Have you ever had an incomplete course in therapy?  YES  NO
- 15) What surgeries have you had? \_\_\_\_\_  
 \_\_\_\_\_
- 16) Is there anything else we need to know about your physical or emotional health?  
 \_\_\_\_\_  
 \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: CELL: \_\_\_\_\_ HOME : \_\_\_\_\_ WORK: \_\_\_\_\_

Email: \_\_\_\_\_