

New England
Family Health Center



Natural Health Care & Psychological Services

LOVE YOUR BODY PROGRAM HEALTH QUESTIONNAIRE & ASSESSMENT

(please circle answer)

- 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, 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 - How often? _____
Does not eating make them worse? YES NO
What makes them better? _____

Dizziness - How often? _____
Does it occur when you bend down to pick something up or get out of a bath quickly? YES NO
From missing a meal? YES NO

Heart palpitations - how often? _____

Circle applicable symptoms

Kidney or bladder infections, painful, frequent or burning urination, none of these?

Lung or respiratory conditions - painful inhalation or exhalation, frequent colds, sinusitis, wheezing, shortness of breath, allergies, asthma, none of these?

Skin - dry, oily, rashes, acne, hives, boils, eczema, psoriasis, allergic dermatitis, none of these?

How often do you have a bowel movement _____

Do you ever have blood with your stools? YES NO

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 alot of sugar, salt, meat, coffee, or any other food? YES NO

If yes, how much? which foods? _____

Are you allergic to any foods? Are there any foods your body doesn't like, i.e. coffee - hyper, dairy - mucous, sugar - pre-menstrual symptoms or general fatigue, fatty, rich foods - indigestion, etc.? Circle which ones.

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, how often and what? _____

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 recurringly or do you have now? _____

11) What surgeries have you had? _____

12) What diet programs have you done in the past and when?

What were your results? _____

Did you have any symptoms? _____

13) Have you ever been hospitalized for psychiatric care? YES NO

14) 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.

15) Have you ever had an incomplete course in therapy? YES NO

Is there anything else we need to know about your physical or emotional health? _____

NAME: _____ AGE: _____ DATE: _____

ADDRESS: _____

PHONE: _____ home
_____ work