



Health Questionnaire

Guest Name: _____ Date: _____

Thank you for choosing The Spa on Green Street where you will discover much about your health and how your body functions. We welcome any questions you may have during the course of your participation.

Below are questions that will assist us in evaluating your health needs. Please check all applicable boxes.

Sleep: How is your sleep?

- restful
- restless
- hard to get to sleep
- wake up often
- get up during the night
- bad dreams
- other: _____

Digestion: How is your digestion?

- adequate
- poor
- acid reflux
- burp often
- bloating
- burning or pain in stomach

Exercise:

- daily
- 4-5 times per week
- 2-3 times per week
- cardiovascular
- resistance
- sports
- enjoy exercising

Sunlight:

- receive daily sunlight outside
- receive daily sunlight through windows
- fluorescent lighting in home/work

Eyewear:

- contact lenses
- glasses
- just for reading
- 2-3 hours/day
- 4-6 hours/day
- 8+ hours/day

Electromagnetic Exposure:

- watch TV 1+ hours daily

- work with computers
- hours talking on phone: _____
- hours talking on cell phone: _____
- wear a pager
- wear a headset
- ride in a truck/car/vehicle 1+ hours daily
- near electrical equipment for long periods (copy machines, high power lines, etc.)

Chemical Exposure:

- work with chemicals
- handle chemicals directly
- chemicals around the workplace
- smoker
- recreational drug use, past or present

Stress:

- minimal
- moderate
- heavy
- severe
- family stress
- job stress

Dental work:

- silver fillings
- composites
- extractions: wisdom, bicuspid, etc.
- bridgework
- partial or full dentures
- gold crowns or inlays
- stainless steel crowns or inlays
- porcelain crowns or inlays
- veneers
- root canals
- posts
- implants
- temporaries
- braces
- bleeding gums
- sensitive teeth

- bad bite
- new cavities
- dental surgery
describe: _____
- need for further dental work
describe: _____

Nervous system:

- lack of focus
- poor concentration
- forgetfulness
- jagged speech
- anxiety
- insomnia
- depression
- feeling wired at times

Bowels:

How are your bowel eliminations?

How often?

- 3 times daily
- once per day
- skip days

Amount

- normal
- too little
- too large

Color

- brown
- black
- whitish
- Other
- lots of mucus
- lots of gas
- foul smell
- intestinal cramping
- international travel

Consistency

- normal
- too hard
- very soft
- diarrhea
- alternating diarrhea/constipation

Urination:

How are your daily urinations?

- every 2 to 3 hours
- too frequent
- sense of urgency
- too small amount
- too large amount
- burning
- dribbling
- up at night several times

Women only:

- pregnant
- breast feeding
- date of last period: _____
- menopause
- hysterectomy
- monthly periods regular (28 days)
- days of your menstrual flow _____
- have taken birth control medication
- bone loss/osteoporosis

Symptoms associated with your period:

- cramping
- bloating
- feeling weak
- mood swings
- cravings
- heavy bleeding
- back pain
- headaches
- bright red blood
- dark clotty blood
- painful breasts
- painful menses

Men only:

- decreased libido
- tire easily
- prostate trouble
- complications with heart
- high blood pressure
- irritability
- decrease in muscular strength
- depressive mood
- feeling burned out

Medications or supplements you are currently taking:

List below your 4 main health concerns in order of importance:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Describe any scars on your body and their causes.

Please list any surgeries, operations, traumas, car accidents, etc.

Check any areas that apply:

- | | |
|---|---|
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Blood Pressure High | <input type="checkbox"/> Blood Pressure Low |
| <input type="checkbox"/> Skin Irritations | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> TMJ Dysfunction |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Cold sores/Herpes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Claustrophobic |
| <input type="checkbox"/> Eczema or Psoriasis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Contagious Disease (please explain): _____ | |

Are you currently under the care of a physician? Yes No If so, for what condition(s)?
