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
altering 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:
☐ Glasses/Contacts ☐ AIDS
☐ Arthritis  ☐ Neck Pain
☐ Blood Pressure High  ☐ Blood Pressure Low
☐ Skin Irritations  ☐ Swollen Joints
☐ Epilepsy  ☐ TMJ Dysfunction
☐ Poor Circulation  ☐ Cold sores/Herpes
☐ Asthma  ☐ Claustrophobic
☐ Eczema or Psoriasis  ☐ Hepatitis
☐ Contagious Disease (please explain): __________________________

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

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