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
- ☐ poor sleep
- ☐ heavy sleep
- ☐ 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
- ☐ nausea
- ☐ vomiting

Exercise:

- ☐ daily
- ☐ 4-5times per week
- ☐ 2-3 times per week

Chemical Exposure:

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

Skin & Hair:

- ☐ rashes
- ☐ ulcerations
- ☐ hives
- ☐ itching
- ☐ eczema
- ☐ pimples
- ☐ dandruff
- ☐ loss of hair

Changes in hair/skin _____

Other hair/skin problems _____

Cardiovascular:

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chest pain
- ☐ irregular heartbeat
- ☐ dizziness
- ☐ fainting
- ☐ cold hands/feet
- ☐ swollen hands/feet
- ☐ blood clots
- ☐ stroke
- ☐ difficulty breathing

Respiratory:

- ☐ cough
- ☐ coughing blood
- ☐ asthma
- ☐ bronchitis
- ☐ pneumonia
- ☐ difficulty breathing when lying down
- ☐ tight chest

☐ production of phlegm(what color) _____

Head, Eyes, Ears & Throat:

☐ dizziness
☐ concussions
☐ migraines
☐ glasses
☐ eye strain
☐ eye pain
☐ see "floaters"
☐ night blindness
☐ ringing in ears
☐ poor hearing
☐ nose bleeds
☐ sinus problems
☐ mucus
☐ dry throat
☐ dry mouth
☐ copious saliva
☐ teeth problems
☐ jaw clicks
☐ grinding teeth
☐ facial pain
☐ gum problems
☐ spots in eyes
☐ recurrent sore throat
☐ mouth/lip sores
☐ headaches
☐ other head/neck problems
_____

Nervous system:

☐ lack of focus
☐ poor concentration
☐ forgetfulness
☐ jagged speech
☐ anxiety
☐ insomnia
☐ depression
☐ feeling wired at times
☐ poor coordination
☐ seizures
☐ areas of numbness
☐ poor memory
☐ concussion
☐ angered easily
☐ stressed

Any treatments for emotional issues?

_____
_____

Bowels:

How are your bowel eliminations?

☐ belching gas
☐ bad breath
☐ rectal pain
☐ hemorrhoids

How often?

☐ 3 times daily
☐ once per day
☐ skip days

Color

☐ brown
☐ black
☐ whitish
☐ other
☐ Lots of mucus
☐ Lots of gas
☐ Foul smell
☐ Intestinal cramping
☐ International travel
☐ Constipation
☐ Watery
☐ Stool sensitive
☐ Abdomen blood?
_____

Consistency

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

Urination:

How are your daily urinations?

☐ too frequent
☐ sense of urgency
☐ burning
☐ dribbling
☐ up at night (how many times?)_____
☐ painful

☐ blood in urine
☐ unable to hold
☐ kidney stones

Musculoskeletal:
☐ neck pain
☐ muscle pains
☐ back pain (where?)____
☐ joint pain (where?)_____
☐ other _____

Women only:
☐ Pregnant
Number of pregnancies ____
Number of births____
☐ date of last period: _____
Period (days) _____
Cycle every ____ days
Last PAP _____
☐ menopause
☐ hysterectomy
☐ breast lumps
☐ miscarriage
☐ vaginal discharge
☐ monthly periods regular (28 days)
☐ days of your menstrual flow ____
Age of first menses_____

Flow: heavy or light _____
Birth control Type_____

Symptoms associated with your period:
☐ cramping
☐ headaches
☐ bloating
☐ feeling weak
☐ mood swings
☐ cravings
☐ heavy bleeding
☐ back pain
☐ bright red blood
☐ dark clotty blood
☐ painful breasts
Age of first menses___
Flow: heavy or light _____
☐ painful menses
☐ PMS

Men only:
☐ decreased libido

Are you a recovering alcoholic? _____

Medications or supplements you are currently taking:

_____

_____

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

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

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

_____

_____

_____

_____

_____

Check any areas that apply:

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

Are you currently under the care of a physician? ☐ **Yes** ☐ **No**
If so, for what condition?

_____

_____

Who is your physician? _____

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