Health Questionnaire

1. Rate your level of health from 1-10. (10=Perfect Health) 0 1 2 3 4 5 6 7 8 9 10
2. Rate your level of stress from 1-10. (10=Unbearable) 0 1 2 3 4 5 6 7 8 9 10
3. Rate your level of physical strength. (10=Best) 0 1 2 3 4 5 6 7 8 9 10
4. Rate your motivation level. (10=Best) 0 1 2 3 4 5 6 7 8 9 10
5. Rate your energy level. (10=Best. 0 1 2 3 4 5 6 7 8 9 10
6. How often do you exercise? ☐ Never ☐ Occasionally ☐ 1-2 days a Week ☐ 3-5 Days ☐ 6-7 Days
7. Length of exercise ☐ None ☐ 10-15 Minutes ☐ 20-30 ☐ 35-55 ☐ 60-90 ☐ Longer _________
8. How much direct sunlight do you get daily? ☐ None ☐ 15 Minutes ☐ 30 ☐ 60 ☐ More ________
9. Do you wear sunscreen and/or sunglasses? ☐ Sunscreen ☐ Sunglasses
10. Do you take Supplements? (Vitamins, Minerals, Digestive Enzymes) ☐ Yes ☐ No
11. If yes, please list them. ____

    ____
12. Do you have any food allergies? ☐ Yes ☐ No
13. If so, list them. ____
14. Do you take any of the following? ☐ antacids ☐ acid blockers ☐ anti-depressants ☐ pain medication

    ☐ blood pressure medication ☐ diuretics ☐ cholesterol medication ☐ over the counter medications

    ☐ blood sugar medication ☐ hormones ☐
15. If so, list them and how often you take them? ____
16. List any other drugs that you take. ____
17. Please check symptoms/problems you experience. ☐ Agitations ☐ Amnesia ☐ Dizziness ☐ Insomnia

    ☐ Tremors ☐ Decreased sex drive ☐ Problems with Appetite ☐ Alcohol and/or Nicotine cravings

    ☐ Drug Abuse ☐ Digestion ☐ Reflux/Heartburn ☐ Gas ☐ Bloating ☐ Constipation ☐ Diarrhea

    ☐ Heart Problems ☐ Anxiety ☐ Cold/ Hot ☐ Cold Hands/Feet ☐ Migraines ☐ Headaches

    ☐ Mental Fog ☐ Mood Swings ☐ Impulse Control ☐ Aggression ☐ Motivation ☐ Sleep-wake cycle

    ☐ Fatigue ☐ Irritability in the afternoon ☐ Get sick if a meal is missed ☐ Hair Loss ☐ Brittle Nails

17. Please check how often you consume these foods/beverages.

	Never	Occasionally	Once a day	Twice a day	3 Times a day	More
Salads	☐	☐	☐	☐	☐	☐
Fruit	☐	☐	☐	☐	☐	☐
Cooked Vegetables	☐	☐	☐	☐	☐	☐
Dairy	☐	☐	☐	☐	☐	☐
Beef	☐	☐	☐	☐	☐	☐
Poultry	☐	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐
Nuts/seeds	☐	☐	☐	☐	☐	☐
Sea salt	☐	☐	☐	☐	☐	☐
Iodized salt	☐	☐	☐	☐	☐	☐
Bread (Whole Grain)	☐	☐	☐	☐	☐	☐
Bread (refined, white)	☐	☐	☐	☐	☐	☐
Cereal	☐	☐	☐	☐	☐	☐
Pasta	☐	☐	☐	☐	☐	☐
Cookies/Cake	☐	☐	☐	☐	☐	☐
Corn products	☐	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐	☐
Sodas	☐	☐	☐	☐	☐	☐
Fruit juice	☐	☐	☐	☐	☐	☐
Caffeinated drinks	☐	☐	☐	☐	☐	☐
Artificial sweeteners	☐	☐	☐	☐	☐	☐
Candy	☐	☐	☐	☐	☐	☐
Food out of a box/can	☐	☐	☐	☐	☐	☐
Ice Cream	☐	☐	☐	☐	☐	☐

18. How much water do you drink daily? _____ ounces or _____ cups

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