Health Questionnaire

Print name: _____ Age _____
First Last

Cell phone # _____ Alternate phone # _____

Email _____

What are your issues? What do you want to resolve? _____

_____

Electronic devices in body? _____ Body parts surgically removed? _____

CURRENT CHALLENGES

Abnormal Cells / Cancer	☐ YES	Environmental Allergies	☐ YES	Nerve Pain / Numbness	☐ YES
Acne	☐ YES	Epilepsy	☐ YES	Not Sleeping Well	☐ YES
Anxiety / Panic Attacks	☐ YES	Fatigue	☐ YES	Obesity	☐ YES
Asthma / Bronchial	☐ YES	Frequent Colds	☐ YES	Pain	☐ YES
Autoimmune Condition	☐ YES	Hair Loss	☐ YES	PMS	☐ YES
Back Pain	☐ YES	Headaches / Migraines	☐ YES	Pregnant	☐ YES
Bladder Issues	☐ YES	Heart Issues	☐ YES	Prostate	☐ YES
Blood Sugar	☐ YES	Heartburn	☐ YES	Restless Legs	☐ YES
Bone Loss	☐ YES	High Blood Pressure	☐ YES	Seasonal Allergies	☐ YES
Bowel Issues	☐ YES	Infertility	☐ YES	Sinus Issues	☐ YES
Breast Pain / Lump	☐ YES	Joint Pain	☐ YES	Skin Issues	☐ YES
Breathing / Lung Issues	☐ YES	Kidney Issues	☐ YES	Teeth Problems	☐ YES
Chest Pain	☐ YES	Libido Issues	☐ YES	Thyroid Issues	☐ YES
Circulation Issues	☐ YES	Liver Issues	☐ YES	Tired / No energy	☐ YES
Constipation / Diarrhea	☐ YES	Medications	☐ YES	Trauma/Emotional Pain	☐ YES
Depression	☐ YES	Memory	☐ YES	Urinary Urgencies	☐ YES
Digestion / Bloating	☐ YES	Menopause	☐ YES	Vertigo / Dizziness	☐ YES
Emotional Issues	☐ YES	Mood Swings	☐ YES	Water Retention	☐ YES

Check **DAILY** or indicate the **# PER WEEK** below.

	Alcohol	Bowels Move	Eat Fish	Exercise	Sugar - (Soda/Tea)	Fast Food	Cigarettes	Coffee
DAILY								
# PER WK								

Diet is mostly: Meat and Vegetables _____ or Carbs/Grains, Sweets, Junk Food _____

Do you usually get the flu shot? _____ Known allergies? _____

Did you get the Covid Shot? _____ Root canals? _____Silver amalgams? (Mercury tooth fillings) _____

Family history? Heart disease ____ Diabetes ____ Mental illness ____Hypothyroid ____Colon ____ Kidney ____

Are you seeing other medical doctors or holistic practitioners? _____

I understand that no doctor-patient relationship exists, but only a contract member-to-member Association relationship. I understand that no prescription or medication, or medical advice should be altered without consulting with my medical doctor. I agree to indemnify and hold harmless the Member Consultant and Getting Well Naturally Private Healthcare Membership Association from any and all claims and damages of every kind to myself or any person or property arising out of or attributed to the services provided or received.

Signature _____ Date: _____

Name of medication?	Medical reason for taking it?	How long?
1.		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Name of supplement?	Take Consistently?
1.	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Based upon the past one to two months, mark **Mostly NO** or **Mostly YES.**

INTESTINAL ISSUES	Mostly NO	Mostly YES
1. Have you taken antibiotics within the last few months?		
2. Are your stools hard or difficult to pass?		
3. Do you have less than one or more than 3 bowel movements per day?		
4. Are your stools not formed (loose) or are thin or like ribbon shaped?		
5. Do you ever have excessive foul smelling bowel gas or stools?		
6. Is it painful to press along the outer sides of your thighs?		
7. Do you have cramping in your lower abdominal region?		
8. Do you often have the feeling that your bowels do not empty completely?		
9. Do you have constipation or a need for laxatives?		
10. Do you have diarrhea?		