Health Factors Screening Questionnaire
Name _____ Date_____
Fill out the following questions as best as you can and leave blank any of them that you do not have specific answers for

Do you have any areas of your body that have not healed well? _____

Do you think any thing could slow your healing? _____

Do you wear shoes that are lace ups and are stable for walking? _____
Diet: Please fill in what you eat for breakfast, lunch, dinner and snacks on an average day:_____
_____

Do you use protein bars or a protein powder supplement? _____
Are you vegetarian? _____
What percent of your fruits and veggies are organic? _____
What percent of your meat or dairy products are organic? _____
Have you ever had Anorexia or Bulimia? _____
Allergies ? Do you have allergies to dust, mold or pollens ? _____
_____
Food Sensitivities: Are you allergic/sensitive to any foods? _____
_____
Supplements: Are you taking a joint support supplement? Y N What dose and what is in it?_____
A Multivitamin How many per day and who makes it? _____
Calcium and magnesium what dose and how many per day _____
Vitamin D what dose_____ Other Supplements(What are the names, doses and brands of what you take): _____
_____
Toxins and Exposures: Have you been exposed to solvents, molds, pesticides, metals or other toxins on a job or elsewhere? _____

Do you have any reactions to medications or supplements_____
Sleep: Do you feel well rested in the morning and during the average day? _____
How many hours of sleep do you get? _____
Do you have trouble falling asleep or staying asleep? _____
Do you have pain or something else that awakens you from sleep and how many times a night do you wake up?_____
Is there a clock radio or lamp or other electrical device near your head or your body at night in your bedroom? _____
What kind of bed and pillows do you use? _____
_____
Exercise: How many days per week do you do exercise aerobically at least 30 minutes?
_____
Do you do any strength or balance training? _____
Stress: How much stress are you under and what are the major stressors? _____
_____

How do you unload stress? _____
Social: How many really good friends do you have that you regularly interact with?
_____
Do you belong to a group that you participate in every month? _____
Do you feel you have enough close friends or relatives that you can talk to about important things? _____
Do you feel pretty connected or mostly isolated in your life? _____
What are the things you really enjoy doing in your free time? _____
_____
Was your childhood filled with rough times or relatively happy? _____
_____
Where are you on happiness scale? 1 very unhappy _____100 very very happy.
Surgeries and other scars: List the year and reason for any scar_____
_____
_____
Has your health changed since you had a particular surgery or a particular scar.
_____
Memory and Cognition: How is your short term memory? Great, So So Very Poor
Have you ever had a head injury? _____
How is your mood? Are you anxious or Depressed? Is your mood any worse in the winter and low light months? _____
_____
Are you generally optimistic or pessimistic? _____
What is your level of hopefulness that your present problem will improve?
1 none_____10 very
Do you label this area of your body(bad knee etc)? _____
Do you get frequent infections or have you had any serous infections that lasted for more than 3 weeks? _____

Have you ever been told that you have Fibromyalgia, Chronic Fatigue Syndrome or Chemical Sensitivities? _____
Do you spray pesticides or herbicides or live near a golf course? _____
Are you sensitive to medications or chemicals or perfumes? _____
Do you use cosmetics? What brand_____
Do you use deodorant and antiperspirant?_____
Energy: Do you feel fatigue like it is difficult to get through a day because of lack of energy?_____
Ligaments: Do you think you have loose joints._____
Do you have type 2 Diabetes or any hormonal problems? _____
_____
Do you have any gastrointestinal symptoms of gas, bloating , runny bowel movements or constipation_____
When were you totally healthy? _____
Is there something or combination of things that set off your present health problem? ___
_____
What are the 2 or 3 most difficult health challenges that you have had? Please list them from earliest to the present? _____
_____
_____
