

Patient Name: _____

DOB: _____

Exercise

How often do you exercise? _____ What type of exercise? _____

For how long? _____ Hobbies: _____

Sleep

How long per night? _____ If you wake up frequently, what is the reason? _____

Nightmares: Y N P

Wake Refreshed: Y N P

Must nap during the day: Y N P

Sleep walk: Y N P

Grind teeth: Y N P

Snore: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

Social Life

Enjoy job: Y N P

Hours worked per week: _____

Excessive exposure to environmental toxins: Y N P

Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: Y N P If so, at what age and by whom: _____

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: Little Moderately Very

Ethnic Background: _____

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Allergies

List all known Allergies (food, drugs, environment): _____