TRINITY Health Questionnaire

TRINITY
HOLISTIC
WELLNESS CENTER

Thank you for taking the time to fill out this form and provide us with details of your health, goals and medical history.
Feel free to save this form to your computer and type in your answers at your convenience.
The boxes where you type your responses will expand to accommodate your text, so you will have as much space as you need.

CLIENT INFORMATION

First Name

Last Name

Street Address

City

State

Country

Phone Number

Email Address

STATISTICS

Date of Birth

Gender

Height (Please indicate units)

Weight (Please indicate units)

Relationship Status

Children

Occupation

Save

HEALTH CONCERNS

What are your main health concerns? (Describe in detail, including the severity of the symptoms)

When did you first experience these health concerns?

How have you dealt with these health concerns? (Please be specific, doctors, hospital, treatments, self-care….)

Have you experienced any success with these approaches?

If you have cancer or any other chronic disease, when were you diagnosed? What is the diagnose?

What kind of medical intervention did you have since your diagnosis? Please elaborate!

What other health practitioners are you currently seeing? List name and speciality.

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GENERAL / PAST MEDICAL HISTORY

Did you have a natural birth? (Home birth, natural hospital birth, medicated birth, cesarean section, water birth)

Did you have jaundice as a baby?

Were you breastfed and for how long?

Did you have childhood vaccinations?

What kind of childhood diseases did you have? (Please list in chronological order)

How would you consider your childhood? (Often sick and lacking energy, somewhere in between, robust and full of energy)

Please list the date and description of any surgical procedures you have had.

Have you had any major accidents in your life? If yes what kind and when.

Have you experienced any major traumas / losses in your life? If so please comment:

How often have you taken antibiotics in infancy/childhood?

How often have you taken antibiotics as an adult?

Save

Please list all prescription and over the counter medications / drugs you are currently taking. Name/Brand/Dose/Frequency/For how long?

Please list all vitamins, minerals, herbs and nutritional supplements you are taking.
Name/Brand/Dose/Frequency/For how long?

Have you ever used steroid, cortisone or similar medication for more than 2-4 weeks?

Please write down the medical conditions your first degree relatives have.

IMMUNE SYSTEM

Have your tonsils or adenoids been removed?

Have you had your appendix removed?

Save

Do you have regular colds and flu's and even fever?

Can you remember when you last had a fever?

GASTROINTESTINAL SYSTEM

Do you suffer from:

- abdominal bloating
- intestinal gas
- burping
- indigestion
- heartburn
- cramps and pain
- None of the above

Do you suffer regularly from constipation, diarrhea or suffer from IBS? (irritable bowel syndrome)

How often do you have a bowel movement?

- 1-3 times per day
- more than 3 times per day
- not regularly every day
- once every second-third day
- once a week

How is your bowel consistency?

- it floats
- it sinks
- stinks (bad odor)
- soft
- watery
- hard
- contains undigested food particles
- has a shiny look with fat droplets floating in water
- has blood and is black
- has mucus
- Well formed and regularly
- NONE OF THE

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How is your bowel movement color?

- Medium brown
- Very dark or black
- Greenish
- Blood is visible
- Variable
- Yellow, light brown
- Chalky colored
- Greasy, shiny

Do you rely on any of the following for bowel elimination? Please be specific of brand/type when using laxatives (Enemas, laxatives, massage)

Do you suffer from nausea related to food?

Do you have or suspect that you suffer any food intolerances or allergy symptoms? Please state all symptoms you have.

CARDIOVASCULAR HEALTH

Do you know your blood pressure?

Do you suffer from any dizziness, light headedness, or ear problems?

Do you have pain in your calves when walking?

Do you have problems with varicose veins?

Do you bruise easily?

Do you have tingling and numbness in hands and feet?

Do you have cold hands or feet?

Do you suffer from hemorrhoids?

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Do you suffer from fluid retention in ankles and feet?

RESPIRATORY SYSTEM

Have you ever suffered from respiratory disease? E.g. bronchitis, sinusitis.

Do you smoke or have been smoking in the past? How long?

Do you have asthma, wheezing or chronic cough?

URINARY SYSTEM

Do you suffer or have suffered from bladder infections? If so when and how many per year/month?

How often do you urinate per day?

Is there any discomfort or pain associated with urination?

Do you experience fluid retention?

Do you experience any lower back pain?

Have you ever suffered from kidney stones?

Do you struggle starting and stopping your urine?

Do you suffer incontinence?

Please describe your normal urine (color, cloudy, blood, odor)

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ENDOCRINE SYSTEM

Do you suffer from hair loss?

Do you have cold hands and feet and are you sensitive to cold?

Do you experience fatigue during the day? please elaborate

Do you have dry skin?

Do you have difficulty losing weight?

Do you gain weight easily?

Do you have low libido?

Do you have regular sex?

Are you tired when you awaken?

Do you have afternoon fatigue?

Do you have thinning of your eyebrows or eyelashes?

Is your voice hoarse?

After waking how long does it take you to get hungry?

These symptoms can be all hormone related. Please tick if applicable:

- anxiety, irritability, anger or agitation
- cramps, heavy bleeding, prolonged bleeding and clots
- water retention/weight gain, bloating throughout your cycle breast, tenderness, lumpiness, enlargement or fibrocystic breasts mood swings, depression, and weepiness
- headaches/migraines
- muscle pains, joint pains, back pain
- acne
- foggy thinking, memory difficulties
- fat gain, especially in the abdomen, hips and thighs

Save

cold hands and feet? Adrenal relation
blood sugar levels vary and you suffer from insulin resistance have irregular periods
have a decreased sex drive
suffer from Gall bladder problems
have infertility
get insomnia
have osteoporosis
have endometriosis
have Polycystic ovaries
have uterine fibroids
have cervical dysplasia? (Abnormal cells on PAP smear)
have allergic tendencies
suffer from any autoimmune disorders
NONE OF THE ABOVE

FOR WOMEN ONLY! Menstrual Periods

Please complete this section to the best of your ability even if you no longer menstruate. It provides valuable information for an accurate assessment. If you are currently going through menopause please answer the following:

When did you stop menstruating?

Did you suffer from night sweats, hot flushes, moods and other vaginal issues?

Is there any other important information regarding your menopause that you think may be relevant?

Please answer the following questions regarding your cycle:
Average length of cycle?

Length of flow?

Regular cycles?

Light, Heavy, Clots and Color of blood?

PMS? (Please describe symptoms)

Do you have or had uterine fibroids?

Do you have or had fibrocystic breast disease?

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Do you have or had endometriosis?

Have you had infertility problems?

Have you had a miscarriage and if yes when?

Have you had any problems with conception or pregnancy?

Do you have anxiety or panic attacks?

Are you currently using or ever used birth control pills? For how long?

Are you currently on or have ever used a long lasting contraceptive (implanon, IUD, depot injection,

Do you or have you used Hormone replacement therapy (HRT)? If so please elaborate.

Do you have any sexually transmitted diseases?

Do/did you suffer from thrush?

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ALLERGIES

Did you have eczema as a child?

Do you suffer from any skin conditions (eczema, psoriasis, itchy skin, hives)?

Do you experience sneezing, persistent runny or itchy nose?

Do your eyes itch, water, and get red or swell up?

Do your symptoms worsen during a particular season?

Do your symptoms change when you go inside or outside?

Are your symptoms worse in your bedroom after going to bed?

Are your symptoms worse in dusty areas?

Are your symptoms worse around animals?

Do you have any relatives with allergies?

Do you have mood swings or feel depressed for no reason?

Do you sometimes feel stimulated or fatigued after meals?

Do you have dark circles under your eyes?

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ORAL HEALTH

Describe your oral condition

- I have amalgam fillings (describe below how many)
- I had amalgam fillings (describe below how many and they were removed)
- I have any root canal fillings (describe below how many)
- I have foreign / prosthetic objects
- I have different metals in my mouth
- I have ulcers
- I have decay
- I have gum bleeding
- I have periodontitis
- I have a dead / dark teeth
- NONE OF THE ABOVE

Please try to describe as accurate as possible.

Describe your oral conditions in your mouth.

If you had Amalgam fillings, how were they removed? (biological dentist / detox / IV's / conventional dentist)

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How are your energy levels during the day?

Rate your energy level out of 1-10 (1 being really tired and 10 being full of energy)?

How do you handle stress?

Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time.

Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

Do you suffer from:

- Migraines
- Headaches
- Poor Memory
- Concentration problems
- Foggy head
- None of the Above

Do you feel often angry / irritable?

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EATING HABITS

Please fill out the diet diary below. It is designed as an insight into your 'average' daily diet. Please describe your food as honestly and extensively as possible. E.g. Veggies (what kind of veggies? How are they prepared? How big is the serving? Do you eat meat with it? How is it prepared?)

If you have changed your diet recently then please also describe what you have been eaten beforehand.
Are you responsible for your own food choices / preparations?

Breakfast

Lunch

Dinner

Do you have any snacks in between the three main meals?

Are there any foods that you avoid? Why do you avoid the specific foods?

Do you crave salty foods?

Do you crave sweet foods?

Do you have any known food allergies or sensitivities?

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Do you eat processed meats? (sausages, bacon….) (how often)

Do you consume meat, if so how many times a week and what kind?

How many times a week do you consume fish and if so what kind?

Do you eat white bread? (how often)

Do you eat pasta and rice? (how often)

Do you eat deep fried foods? (how often)

Do you eat soy products? (how often)

Do you eat GLUTEN?

Do you eat DAIRY?

Do you eat packaged breakfast cereals? (how often)

Do you have problems with digesting fat?

How do you feel after you have been eaten? (tired, energized, bloated)

Do you follow any special diet and if so why and since when?
(vegan, vegetarian, paleo, ketogenic, raw, gluten free……..)

If you are a vegan/vegetarian are you prepared to eat meat or fish if advised to?

Do you eat snacks or sweets not covered in your diet diary?

Do you eat out and if so what do you normally eat?

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If you are carrying excess fat, where is it located?

- Hips
- Thighs and leg area
- Abdominal (belly area)
- Everywhere
- No

Is there anything else we should know about your current diet, history or relationship to food?

DRINKING HABITS

How many liters of 'water' do you drink a day?

How many liters of liquid other than water do you drink a day?

Do you drink coffee and if so how many cups and when?

Do you drink alcohol and if so how often per week/month (however applicable)?

When you do you drink alcohol how much do you consume?

Did you drink alcohol in your past?

Do you drink fruit juice and if so how much?

Do you consume liquid with your meals?

Do you get thirsty?

Do you drink alkaline water?

Do you have a water filter?

Save

EXERCISE HABITS

How often a week do you exercise?

What kind of exercise do you perform?

How do you feel after exercise?

Where do you exercise?

Do you get cramps or sore muscles after exercise?

SLEEPING HABITS

When do you go to sleep?

When do you wake up?

How many hours of sleep do you get per night?

How many hours of sleep do you feel like you need a night?

How long did it take you to fall asleep?

Do you wake during the night? How often?

Was there a reason you woke up (baby, bathroom, other noise disturbances)?

Did you have trouble falling back asleep?

If you have issues sleeping, do you use any medication or therapy?

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TOXIC EXPOSURE

Do you have any hobbies or a job which exposes you to chemicals and pesticides such as working in a lab, farming, home garden, carpentry, hairdressing, painting, dentistry ? Please list all!

Have you been a frequent flyer?

Have you had many X Rays, CT scans?

Do you live in a house, flat or other accommodation that was built before 1970?

Have you lived in a building with mold or persistent unrepaired water leaks?

Do you dry clean your clothes?

Do you use fragrances?

Do you use conventional care products and cosmetics?

Do you drink water from plastic bottles?

Have you eaten much fish before or since you've been ill, especially tuna, swordfish, shark, or other large fish near the top of the food chain?

Save

Do you have stress, anger and resentment with siblings? If yes, please describe:

Do you have stress, anger and resentment with parents/children? If yes, please describe:

How do you rate your parents care for you?

- Abuse
- Neglect
- Caring
- Smothering
- Domineering

Do you have stress, anger and resentment with spouse or partner? If yes, please describe:

Do you have stress, anger and resentment with work colleagues? If yes, please describe:

Do you have a hard time to stop repeating thoughts?

Are you able to calm yourself with breathing exercises?

Do you have signs like stiff neck, twitching eye or other nerve signals that you are stressed?

Do you worry a lot about money and being able to pay the bills?

Do you have a positive outlook on earnings and a confident attitude that you manage the future?

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Has money been a hot subject with loads of ups and downs?

Do people say: "thank you, well done, great achievement"?

Do people admire you and follow your lead?

Do you think you do not get adequate recognition and appreciation?

Do you need to perform work that you: do not like? / hate? / make you sick?

Do you have stress with work colleagues?

Do you have to work under pressure and in a critical situation?

Is your work uninspiring and boring?

What do you do for work?

Do you have any hobbies and yes what kind?

Do you know your life purpose or have a strong passion that motivates you?

Do you have any regular spiritual praxis? (meditation, prayer, yoga)

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OTHER

Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if not.

Who in your family or on your health care team will be most supportive of you making lifestyle changes?

Please describe any other information you think would be useful in helping to address your health concerns:

What are your health goals and aspirations?

Though it may seem odd, please consider why you might want to achieve these health goals for yourself:

Please attach your latest test results (blood, stool, hair, saliva, scans) or any other medical report.

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