NATURAL CHIROPRACTIC HEALING

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GENERAL HEALTH QUESTIONNAIRE

Name _____

Date _____ **Age** _____

Instructions:

1. Circle YES or NO to answer the questions.
2. Fill in Your Score where indicated.

Overall Well-Being

Consider Your Current Symptoms and Overall Sense of Well-Being and Answer:

Do You Feel Basically Healthy?	Yes No
Do You Consider Yourself Happy?	Yes No
Do You Consider Your Life to be well balanced?	Yes No
Do you take responsibility for your own life and health condition?	Yes No

List any negative health symptoms you're experiencing: _____
_____
_____
_____

What will be your health and life experience 1 year from now? _____
_____
_____
_____

We wish to support our patients' health in anyway they choose. In an effort to provide you with the best treatment plan, please circle your current level of commitment to your health.

0_____1____2____3____4_____5_____6_____7_____8____9____10

Not committed Just trying out Not interested in nutritional support or following a nutritional/colon care treatment plan.	Unsure	Fully committed Needs full support, treatment plan and nutritional/colon Ready to make a lifestyle change!

You Have Chronic Inflammation in Your Body?

If You Answer 3 or More Questions "YES" You May Have Chronic Inflammation.

Do you have elevated cholesterol or triglycerides?		
Do you have numbness or tingling in your arms or legs?	Yes	No
Do you eat meat, commercially baked sweets, fried foods, or use vegetable oil daily?	Yes	No
Do you consume fish less than two times per week?	Yes	No
Do you have high blood pressure, asthma, or colitis?	Yes	No
Do you smoke?	Yes	No
Do you have gingivitis, periodontal disease, or not have regular dental cleansings and check-ups at least once every six months?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____

Poor Nutrition and Lifestyle

Do You Have Poor Nutrition and Digestion?

If You Answer 4 or More Questions "YES" You May Have Poor Nutrition and Digestion.

Do you regularly include fast food in your diet (three or more times per week)?	Yes	No
Do you experience belching, bloating, or persistent fullness soon after eating, or do you experience excess gas often?	Yes	No
Do you experience heartburn or acid reflux two or more times per week?	Yes	No
Are you allergic to any specific foods?	Yes	No
Do you feel fatigued or lethargic after eating?	Yes	No
Do you commonly have bad breath or a bad taste in your mouth?	Yes	No
Do you use digestive aids such as laxatives, antacids, or acid-blocking drugs?	Yes	No
Do you often feel "older" than you should for your age?	Yes	No
Does your skin look sallow, gray, puffy, wrinkled, or aged?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____

Do You Have Abnormal Blood Sugar Levels? Are You Pre-Diabetic or At Risk?

If You Answer 3 or More Questions "YES" You Could Have Abnormal Blood Sugar Levels.

Does your waistline extend beyond your hips or are you overweight?	Yes	No
Do you become tired or light-headed or do you feel the need to eat again just two or three hours after your last meal?	Yes	No
Do you eat dried beans e.g. pinto, navy, black, etc. less than three times per week?	Yes	No
Do you exercise less than three times each week?	Yes	No
Do you eat two or more servings of bread, pasta, candy, colas, or fruit juice a day?	Yes	No
Do you eat fewer than five servings of fresh, raw vegetables and fruits per day?	Yes	No
Do you have high blood triglyceride levels or suffer from hypertension?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____

Do You Have Impaired Cellular/Mitochondrial Function?

If You Answer 3 or More Questions "YES" You May Have Impaired Cellular Function.

Are you frequently tired for no reason (especially around 3 P.M.)?	Yes	No
Do you have stiff and sore muscles (unrelated to recent exercise)?	Yes	No
Do you have poor stamina, shortness of breath, or feel exhausted after exercising?	Yes	No
Do you exercise less than two hours per week?	Yes	No
Have you ever been diagnosed with iron deficiency or do you have heavy menses?	Yes	No
Do you look older than your true age?	Yes	No
Have you ever been exposed to toxic chemicals or heavy metals?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____ | ____

Exposure to Toxins

Is Your Detoxification Capacity Impaired?

If You Answer 4 or More Questions "YES" Your Body Needs Help to Detoxify.

Do you become physically ill when exposed to strong smells (perfume, auto-exhaust, cigarette smoke, etc.)?	Yes	No
Do you use chemical cleaners or solvents at home, at work, or in your hobbies?	Yes	No
Do you live in a house/apartment or work in an office less than 5 years old?	Yes	No
Do you have any amalgam (mercury) dental fillings?	Yes	No
Are you prone to side effects from medications or supplements, or have you become more sensitive to the effects of alcohol or caffeine (reduced tolerance)?	Yes	No
Do you have fewer than 2 bowel movements daily?	Yes	No
Do you smoke?	Yes	No
Do you have or have you ever had breast implants?	Yes	No
Do you have any pets, especially dogs, cats, birds, or other furred or feathered animals?	Yes	No
Do you wake up often during the night to urinate?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____ | ____

Is Your Home and/or Work Environment Toxic?

If You Answer 4 or More Questions "YES" Your Home or Office Needs a "Health Makeover."

Do you have carpet in your home?	Yes	No
Do you vacuum less than 3 times per week?	Yes	No
Have you changed or cleaned your air filters in the last 30 days?	Yes	No
Do you routinely drink tap water?	Yes	No
Are your clothes and bedding washed in unfiltered city water?	Yes	No
Have you recently repainted your home on the inside?	Yes	No
Have you noticed any black spots or mold on your air vents or walls?	Yes	No
Have you had your air vents cleaned in the past year?	Yes	No
Do you use natural cleaning agents or chemical based cleaners in your home?	Yes	No
Do you use chemical fertilizers, insecticides, or pesticides?	Yes	No
Does your home contain a quality air purification system?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____ | ____

Impaired Immune System

What is the Quality of Your Immune System Function?

If You Answer 4 or More Questions "YES" Your Immune System May be Overworked.

Do you catch colds or the flu easily?	Yes	No
Do colds, flu, or other infections tend to linger in your system more than 5 days?	Yes	No
Do you have a chronic cough, scratchy throat, sinus congestion, or excess mucous production making it necessary to clear your throat often?	Yes	No
Do you have seasonal allergies or known allergies to dust, animals, or mold?	Yes	No
Have you ever been diagnosed with an autoimmune disease?	Yes	No
Do you have dark circles under your eyes?	Yes	No
Do you have difficulty seeing at night, or do you have white spots on your fingernails?	Yes	No
Have you recently had any vaccinations?	Yes	No
Have you or anyone in your family served in the military in the last 15 to 20 years?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____ ____

Is Your Liver Impaired by Your Emotions?

If You Answer 5 or More Questions "YES" Your Liver May Be Impaired.

Do you feel angry from time to time?	Yes	No
Are you agitated easily?	Yes	No
Do you have frequent mood swings?	Yes	No
Is it hard to stay in a good mood?	Yes	No
Do you run out of energy during the day?	Yes	No
Do you have brown spots on your skin or age spots?	Yes	No
Does your skin break out or is it blemished?	Yes	No
Are your emotions often on a "roller coaster"?	Yes	No
Do you later have to apologize for your bad moods to friends, family, co-workers, etc.?	Yes	No
Is there always "something wrong" in your life?	Yes	No
Have you ever been physically or sexually abused?	Yes	No
If you are upset, is it best not to talk to you about what's going on?	Yes	No
Do you get annoyed by the "fake" cheeriness of others?	Yes	No
Do these questions irritate you?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____ ____

Are Your Kidney and Urinary Systems Functioning Properly?

If You Answer 5 or More Questions "YES" Your Kidneys May Be Overworked.

Do you have pain in your muscles and joints?	Yes	No
Have you had kidney or bladder infections in the last year?	Yes	No
Have you experienced ankle pain or swelling in the last year?	Yes	No
Do you have left shoulder pain?	Yes	No
Do your fingernails chip or break easily?	Yes	No
Do you have puffiness, "bags", or dark circles under your eyes?	Yes	No
Is your hair thinning?	Yes	No
Do you have frequent scalp irritations?	Yes	No
Do you have painful, harsh menstrual cycles?	Yes	No
Do you wake up often during the night to urinate?	Yes	No
Do you feel exhausted in the morning even after sleeping 8 or more hours?	Yes	No
Have you ever been diagnosed with thyroid problems?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____ ____

Do You Have Parasites, Viruses, Fungi, or other Microbes Inside Your Body?

If You Answer 4 or More Questions "YES" You May Need a Thorough Parasite Cleanse.

Do you have any yellowish discoloration on your fingernails or toenails?	Yes	No
Do you have athlete's foot or noticeable foot odor?	Yes	No
Do you have a history of yeast infections?	Yes	No
Have you been "mouthed", scratched, or licked by an animal in the last 6 months?	Yes	No
Have you been bitten by mosquitoes or bugs?	Yes	No
Do you feel bloated, grumpy, or gassy after meals?	Yes	No
Have you eaten at a sushi bar, salad bar, or buffet recently?	Yes	No
Have you ever picked food up off the floor and eaten it?	Yes	No
Do you often crave sugar, sweets, or bread?	Yes	No
Do you experience anal itching?	Yes	No
Do you have dandruff?	Yes	No
Do you have indoor pets?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____ | ____

Hormonal Imbalance

Are Your Adrenal Glands Functioning Properly?
If You Answer 3 or More Questions "YES" Your Adrenal System May Be Suffering.

Do you frequently feel "stressed out"?	Yes	No
Do you have difficulty falling asleep or maintaining sleep through the night?	Yes	No
Do sudden noises make you jump?	Yes	No
Do you become dizzy or light-headed when standing up too quickly?	Yes	No
Do you crave salt or sugar?	Yes	No
Do you drink coffee?	Yes	No
Have you taken any diet pills in the last 3 years?	Yes	No
Do you drink any highly caffeinated beverages such as soft drinks or energy drinks?	Yes	No
Do you exercise less than 3 times per week?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____ | ____

Is Your Thyroid Imbalanced?
If You Answer 4 or More Questions "YES" Your Thyroid May Be Imbalanced.

Are you frequently cold or do you have cold hands and feet?	Yes	No
Do you have trouble "getting going" in the morning?	Yes	No
Do you often feel sad or depressed, especially in the morning?	Yes	No
Are you unable to lose weight despite improving your diet and exercising more?	Yes	No
Do you have diffused or "patches" of hair loss from your head, arms, or legs?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____ | ____

Are Your Sex Hormones Reduced in Production or Quality?

If You Answer 2 or More Questions "YES" Your Sex Hormones May Be Reduced.

Are you "flabby" or have you experienced a loss of muscle tone?	Yes	No
Do you suffer from a low sex drive?	Yes	No
Do you frequently experience headaches or migraines?	Yes	No
Do you have Pre-Menstrual Syndrome (PMS)?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____|____

FOR WOMEN - Is Your Body Out of Balance?

If You Answer 6 or More Questions "YES" Your Body is Out of Balance!

Are you very easily fatigued?	Yes	No
Do you suffer from Pre-Menstrual Syndrome (PMS)?	Yes	No
Do you have painful menses (periods)?	Yes	No
Do you frequently experience depression before or during menstruation?	Yes	No
Is your menstrual cycle prolonged in duration or excessive in terms of blood flow?	Yes	No
Are your breasts overly sensitive or "painful" before, during, or after menses?	Yes	No
Do you menstruate too frequently (more than once per month or sporadic flow)?	Yes	No
Do you produce a vaginal discharge?	Yes	No
Have you had a hysterectomy or had your ovaries removed?	Yes	No
Do you have menopausal "hot flashes"?	Yes	No
Is your menses irregular or absent altogether?	Yes	No
Do you have acne or other skin blemishes that worsen during menses?	Yes	No
Have you felt depressed for 3 months or longer?	Yes	No
Do you have hair growth on your face or body?	Yes	No
Do you have or desire sex less than 2 times each month?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____|____

FOR MEN - Is Your Body Out of Balance?

If You Answered 6 or More Questions "YES" Your Body May Be Out of Balance!

Are you very easily fatigued?	Yes	No
Do you have premature ejaculation?	Yes	No
Is urination difficult or do you "dribble" i.e. can't stop completely?	Yes	No
Have you experienced or are you experiencing prostate trouble?	Yes	No
Do you often wake up during the night to urinate?	Yes	No
Do you have pain on the inside of your legs or heels?	Yes	No
Do you have feelings of incomplete bowel evacuation or "not emptying fully"?	Yes	No
Do you have problems sleeping	Yes	No
Do you avoid even routine or mild physical activity?	Yes	No
Do you run out of energy during the day?	Yes	No
Do you experience leg nervousness or "twitching" at night?	Yes	No
Do you have difficulty falling asleep or maintaining sleep through the night?	Yes	No
Have you felt depressed for 3 months or longer?	Yes	No
Do you have or desire sex less than 2 times each month?	Yes	No

What is your score? Add up the number of "YES" and "NO" responses. ____|____

Note — This General Health Questionnaire is not intended to diagnose, treat, cure or prevent any disease. No statements herein have been evaluated by the FDA nor is any endorsement thereof implied or given.We advise use of this Questionnaire simply as a starting point for consideration of any negative health symptoms you may be experiencing and potential preventative measures or as a resource for further discussion with your healthcare provider.