Questionnaire

Client/or Responsible Party

Signature:_____

Print Name:_____

Date:_____

Profession:_____

Address:_____

City:_____

State:_____

Zip:_____

Phone:_____

Cell:_____

Email:_____

Date of Birth:_____

Place of Birth:_____

Time of Birth:_____

Questions:

Are you pregnant?_____

Do you have a pace maker?_____

Do you have screws/plates etc?_____

Do you have any contagious or serious illness?_____

Do you have any medical diagnosis?

_____

_____

1. Number of organs removed including wisdom teeth (specify)

   _____

2. How many prescriptions are you on and what are they?

   _____

   _____

Questionnaire

3. How many cigarettes smoked per day?_____
4. How many steroid type drugs used in the last year?_____
5. Number of metal dental fillings, not gold or silver_____
6. Number of street drugs currently used and specify_____
7. Unresolved mental factors (I,e, things that still bother you)

   _____

   _____
8. How responsible do you feel for your own health 1-10_____
9. How much of your diet is fat_____
10. How much stress do you have 1-10 _____
11. How many servings of sugar per day_____
12. How many exercise sessions per week (20+ mins)_____
13. How many servings of alcohol per day _____
14. How many caffeine servings per day_____
15. Number of x-ray/chemical/toxic exposures in the last year

    _____
16. How many major injuries (i.e. broken bones, accidents, etc.)_____

    _____
17. How many major infections (i.e. pneumonia, chicken pox, etc.)_____

    _____
18. How many glasses of water (8oz) per day_____
19. How many lbs are you overweight (or kilos)_____

Are you open to receive specials or information via email or phone from this specialist?

_____

Initial _____