Hol Health Harmony and ROC Chiropractic Confidential Health Questionnaire

Fax: **Consultation Date**: _____

E-mail: **Consultation Time:** _____

***** All of your personal information will remain strictly confidential! *****

Name: _____
E-mail Address: _____
Street Address: _____

City/State/Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Date of Birth: _____ Place of Birth: _____

Age: _____ Gender: _____ Height: _____ Current Weight: _____

Would you like your weight to be different? _____ If so, what? _____

Occupation: _____ How many hours do you work per week? _____

Relationship Status: _____ Children? _____

Blood Type (if known):_____

Referred by:_____ _____

Please list in order of importance your top 3-5 health concerns:
_____
_____
_____
_____
_____
_____

Describe the symptoms you are currently experiencing:
_____
_____
_____
_____
_____
_____
_____
_____

What would you like to accomplish/gain from this consultation?
_____
_____
_____
_____
_____
_____

Do you sleep well? _____

Do wake up during the night? _____ If so, what time(s)?
_____

What time do you go to bed? _____ What time do you generally wake-up? _____

How do you feel when you wake up?
_____

Do you drink caffeinated drinks? _____ How much & how often?
_____

Do you smoke? _____ How much & how often?
_____

If no, why, how and when did you quit?
_____

Do you drink alcohol? _____ How much & how often?
_____

Do you drink soda (diet or regular)? _____ How much & how often?
_____

What role does exercise play in your life?
_____

How much water do you drink per day?
_____

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/non- prescription medications, aspirin, laxatives, diet pills, or any other supplements? Please list all below including name brands and amounts:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any known allergies to medications or herbs? Please list all -
_____
_____
_____
_____
_____
_____

Are you currently under a practitioner's care for a specific health issue? If so, what treatments are you undergoing?

_____
_____
_____
_____
_____
_____

Please list any surgeries, accidents, injuries or childhood diseases you have had along with the type and date:

_____
_____
_____
_____
_____
_____

What are your eating/drinking habits these days?

Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

What were your eating habits like as a child? (List types of foods)

_____

_____
_____
_____
_____
_____
_____

What percentage of your food is home cooked?
_____

How often do you eat out?
_____

What are the three worst foods you eat each week?
_____
_____
_____

What are the three healthiest foods you eat each week?
_____
_____
_____

Do you crave sugar? _____ Do you crave salt?
_____

Do you feel tired, bloated, and/or gassy after meals?
_____

Do you experience constipation or diarrhea often? _____ When & how often? _____
_____
_____
_____
_____

Do you feel excessively hungry? _____ Do you have a poor appetite? _____

Please list any known food allergies and/or intolerances:
_____
_____
_____
_____
_____

Within the last two years, have you been tested for any of the following hormones?

1) DHEA _____
2) Cortisol _____
3)Testosterone _____
4) Estrogen _____
5) Progesterone _____

Were your hormone levels normal? _____ If not, please explain:
_____
_____
_____
_____
_____

Have you had any previous colon cleansing sessions with a certified colon therapist? _____
When? _____ How many?
_____

Family Health History

Diabetes? _____ Kidney disease?
_____
Heart Disease? _____ Arthritis?
_____
Asthma? _____ Gallbladder disease?
_____
Cancer? _____ Type of cancer?
_____

Stomach/Intestinal disorders? _____ Other: _____

Mother: Age: _____ Died from? _____

Father: Age: _____ Died from? _____

Maternal Grandmother: Age: _____ Died from? _____

Paternal Grandmother: Age: _____ Died from? _____

Maternal Grandfather: Age: _____ Died from? _____

Paternal Grandfather: Age: _____ Died from? _____

WOMEN ONLY:

Age of your first period: _____ Are your periods regular? _____

How frequent? _____ # of pregnancies _____

How many days is your flow? _____- _____

Do you experience PMS? _____ Is it mild or severe? _____

Are you peri-menopausal? _____ When did this change first occur? _____

Are you menopausal? _____ When was your last period? _____

List your symptoms of peri/menopause:

_____

_____

_____

_____

_____

How many children have you delivered and how were they born (vaginally or by cesarean)?
_____-
_____
_____
_____
_____

Were there complications associated with these births? _____
Please explain: _____
_____
_____

Did you receive antibiotics during labor? _____
Have you ever had a miscarriage or an abortion? _____
How many? _____

Health Check list – Please answer "**Y**" or "**N**". Leave blank if symptom does not apply

General Symptoms:	**Ears:**	**Eyes:**
Allergies - Colds- Depression - Fatigue - Fainting spells - Insomnia - Frequent illness -	Itchy ears - Earaches - Ear Infections - Ringing in Ears - Ear Drainage - Hearing Loss -	Watery Eyes - Itchy or red eyes - Blurred Vision - Tunnel Vision -
Nose:	**Emotions:**	**Heart/Cardiovascular:**
Stuffy nose - Sinus problems - Hay Fever -	Mood Swings - Anxiety - Nervousness -	Irregular heartbeat - Rapid heartbeat - Chest pains -

Sneezing - Excess Mucus - Nose Bleeds -	Anger - Irritability - Depression -	Swelling of ankles - Poor Circulation - High/Low blood pressure -
Joint/Muscle: Joint pain - Arthritis - Muscle pain - Varicose veins - Back pain -	**Head:** Dizziness - Headaches -	**Lungs/Respiratory:** Chest congestion - Asthma - Shortness of breath - Bronchitis - Chronic Cough -
Mind: Poor memory - Confusion - Learning -	**Disabilities:** Stuttering - Poor concentration -	**Mouth/Throat:** Chronic Sore throat - Swollen gums - Canker sores - Sensitive teeth-nerves -
Energy: Fatigue - Apathy - **Lethargy:** Hyperactivity - Restlessness -	**Digestive Tract:** Nausea - Diarrhea - Constipation - Bloating - Belching - Excess Gas - Heartburn/Reflux -	**Urinary Tract** Bladder trouble - Kidney failure - Kidney infection - Kidney stones - Prostate trouble - Chronic UTI's - Burning urination -

Skin:	**Weight:**	**Women:**
Acne -	Binge eating -	Genital itch/discharge-
Boils -	Cravings -	Fibrocystic breasts -
Hives or rashes -	Excessive weight -	Hysterectomy -
Hair loss -	Compulsive eating -	Irregular pap tests -
Excess sweating -	Water retention -	Yeast infections -
Dryness -	Under weight -	Vaginitis –
Eczema or psoriasis -	Eating disorders -	Endometriosis -
Sensitive skin -		Absence of period -
Bruising easily -		Infertility -

DISCLAIMER

The health and nutritional information you receive from Holhealth Harmony/Nutritional therapist during a consultation, whether given by phone, in person at your home, in the office, through lectures, workshops, brochures, or newsletters is not intended to diagnose or prescribe. It consists of combined information from many educational sources and points of view to help you make informed decisions regarding your desired level of health. The sources behind this information include: modern medicine, ancient Chinese medicine, naturopathic medicine and the therapist's personal research, study, and life observation as well as client results and experiences. Anyone deciding to act upon any information mentioned during a consultation shall assume full responsibility for any effects of their actions. There are risks and unforeseen results associated with any change of diet and lifestyle. It is not recommended that you apply these changes unless you are willing to assume full responsibility for the risks you choose to take. If you choose to implement dietary and lifestyle changes without consulting your physician, which is your constitutional right, you are, in effect, prescribing for yourself. When in doubt of the appropriateness of any treatment, whether recommended to you by a practitioner or by your own intuition, please consult a physician. Consultation information should not be used as a substitute for a physician's advice. It is our hope that you do choose a physician who realizes the importance of a healthy diet and lifestyle choices in correcting imbalances in the body. Please be aware that you have the right to make

your own health decisions based on any information made available to you. **YOU** are the driving force in guiding yourself on a path to radiant health!

ACKNOWLEDGEMENT

I accept the terms and conditions of this disclaimer. I acknowledge that any and all information given to me by Holhealth Harmony and Jennifer Doctorovich is to be used for educational purposes only. I also acknowledge that neither Holhealth Harmony and Jennifer Doctorovich claim to be medical doctors and will not prescribe for or diagnose any disease or condition. Jennifer Doctorovich, NTP nutritional consultant has been thoroughly trained and certified by the Nutritional Therapy Association.

The preceding answers are true and correct to the best of my knowledge. If I experience any changes in my health or current medications, I will immediately communicate this information to Holhealth Harmony Nutritional Therapy and Jennifer Doctorovich. I further acknowledge that I am fully responsible for any decisions and/or changes I make regarding my health and I will not hold Holhealth Harmony and Jennifer Doctorovich liable for my own decisions, any results of my decisions or of any natural treatment or advice I may receive.

Client Name (print): _____

Client Signature: _____ Date: _____

CONSULTATION DURATIONS AND FEES

Initial Consultation (up to 60 minutes) - $45 (Special Rate)
Follow-up Consultation (up to 1 hour) - $65

½ hour consultations $45
Each additional quarter hour is $15
Consultations outside regular office hours – additional $25
Phone Consultation (1 hour) - $65
In home consultations – $150 + travel expenses
Nutritional Therapy Packages (including consultations and personal training) Please ask for rates
EVOX $85 per session; Ask for rates on packages

Cancellation policy: Less than 24 hours – ½ consult fee. No show – full consultation fee.

To pay for your consultation, call 646-263-4377 or send a check or money order to the address below along with your completed questionnaire. Payment is due upon the completion of your consultation. All fees, including supplements and tests are to be paid at the time of service or if an order will need to be placed.
Cash only (including check or credit card) Insurance is not accepted for nutrition. Check your health policy or tax free flex accounts for details.

If paying by check or money order, please make payable to:

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