Chesapeake Holistic

HEALTH SURVEY QUESTIONAIRE

FIRST-TIME CLIENTS: **Complete form: Please email to info@chesapeakeholistic.com or fax 410.757.6742 – before your appointment.**

FOLLOW-UP VISITS: **Complete and print the form, and bring with you to the appointment.**

(Form must be completed prior to your appointment, to enable effective time-scheduling for your session and for other clients.)

Name: ______________________ **Date:** ______________________

Please place a check mark next to any symptoms you are CURRENTLY experiencing:

HEAD
- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

EYES
- ☐ Watery, dry or itchy
- ☐ Swollen, reddened or sticky eyelids
- ☐ Bags or dark circles
- ☐ Blurred or tunnel vision

EARS
- ☐ Itchy
- ☐ Drainage from ear
- ☐ Earaches
- ☐ Ear infections
- ☐ Ringing in ears
- ☐ Hearing loss

NOSE
- ☐ Itchy nose
- ☐ Stuffy nose
- ☐ Sneezing attacks
- ☐ Sinus problems
- ☐ Hay fever/ allergies
- ☐ Excessive mucus

MOUTH/ THROAT
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Loss of voice
- ☐ Chronic coughing
- ☐ Bleeding gums
- ☐ Chapped lips
- ☐ Bad breath
- ☐ Mouth sores, ulcers
- ☐ Excessive mucus
- ☐ Swollen or discolored tongue, gums, lips
- ☐ Frequent throat clearing
- ☐ Teeth grinding/clenching
- ☐ Cracks in mouth corners

HEART
- ☐ Heart palpitations
- ☐ Chest pain
- ☐ Tight feeling in chest
- ☐ Rapid/pounding heartbeat

LUNGS
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest congestion
- ☐ Smoker
- ☐ Difficulty breathing
- ☐ Shortness of breath

DIGESTIVE TRACT
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloated feeling
- ☐ Belching
- ☐ Passing gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Irritable bowel
- ☐ Heartburn
- ☐ Acid reflux
- ☐ Intestinal pain
- ☐ Stomach pain

SKIN, HAIR, And NAILS
- ☐ Acne
- ☐ Hives
- ☐ Rashes
- ☐ Hair loss
- ☐ Dry skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hot flashes
- ☐ Excessive sweating
- ☐ Thin, peeling nails
- ☐ Ridges on nails
- ☐ White spots on nails

EMOTION
- ☐ Anger
- ☐ Anxiety
- ☐ PMS
- ☐ Panic
- ☐ OCD
- ☐ Fear
- ☐ Irritability/aggression
- ☐ Mood swings
- ☐ Depression

JOINTS/ MUSCLE
- ☐ Stiffness
- ☐ Arthritis
- ☐ Muscle weakness
- ☐ Muscle pain/aches
- ☐ Joint pain or aches
- ☐ Limitation of movement
- ☐ Overall feeling of weakness or tiredness

WEIGHT
- ☐ Excessive weight
- ☐ Underweight
- ☐ Emotional eating/drinking
- ☐ Binge eating/drinking
- ☐ Water retention

Craving certain foods:
- ☐ Sugar
- ☐ Caffeine
- ☐ Salt
- ☐ Alcohol
- ☐ Chocolate

ENERGY/ ACTIVITY
- ☐ Interrupted sleep
- ☐ Insomnia
- ☐ Hyperactivity
- ☐ Restlessness
- ☐ Apathy, lethargy
- ☐ Fatigue, sluggishness
- ☐ Frequent illness

MIND
- ☐ Poor memory
- ☐ Confusion
- ☐ Poor comprehension
- ☐ Stuttering/stammering
- ☐ Difficulty with focus or concentration
- ☐ Trouble making decisions
- ☐ Poor physical coordination

URO-GENITAL SYSTEM
- ☐ Vaginal dryness
- ☐ Erectile dysfunction
- ☐ Disinterest in sex
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Genital itch
- ☐ Genital discharge
- ☐ Bed wetting

Additional information:

Please describe any recent illness (e.g., flu, cold, infection) or injury. List all prescription medicines you are CURRENTLY taking.

List any food (e.g., shellfish, citrus…) or drug allergies you have: