

# **SALUTOGENESIS QUESTIONNAIRE**

(Please fill out the following to the best of your ability)

What is the main reason why you are seeking integrative medical care? (please answer in the space provided)

## **Personal Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Place of birth: \_\_\_\_\_

Birth order: \_\_\_\_\_

Relationship (please check):

Single

Married/Relationship

Divorced/Widowed

Do you have children: Yes      No

If you answered 'yes' above, please list your children's ages:

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Please list your hobbies:

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Do you, or have you ever, smoked Cigarettes? Yes      No

If yes, how much and how long?

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Have you used any other recreational drugs? If so, what, and how much/long (please answer in the space provided):

Do you, or have you, consumed alcohol? Yes      No

If you answered yes to the above:

How frequently do/did you consume alcohol?

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How much alcohol do/did you normally drink in one setting?

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**Allergies**

Please list any allergies you have or have had:

**Medication**

Please list prescription medications you are currently taking:

Supplements (Please list everything):

**Physical activity**

Please describe your daily activities and any physical exercise you do, and how often:

## **Mental and/or Physical Stress**

Please list and describe any mental or physical stresses you are experiencing:

Are you sexually active? Yes      No

If you answered yes, how satisfied are you with your sexual life?

## **Spirituality/Faith**

Please describe what brings meaning to your life:

## **Family Medical History**

Please list any illnesses for the following:

Mother :

Father:

Siblings:

## **Occupation**

What is your occupation? \_\_\_\_\_

Please list any environmental exposure to toxins you have experienced as a result of your occupation:

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## **Medical Problems**

(please check all that apply)

Insomnia and sleep problems

Diabetes Mellitus

Thyroid problem

Hypertension

Heart disease

Stroke

Dementia

Asthma

Emphysema/COPD

High cholesterol

Recurrent infections

Overweight

Arthritis

Autoimmune disorders

Fibromyalgia

Fatigue

Irritable bowel

Cancer  
Other

If you checked “recurrent infections,” what kind?

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If you checked “cancer,” what kind?

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If you checked “other,” please list:

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### **Past Surgeries**

Please list any surgeries or operations you have undergone and when:

### **Trauma and injury**

Please list any trauma or injury you have experienced (breaking a bone is not necessary).

## Adverse Childhood Experiences

Please check all that apply:

Parental divorce or seperation?

Physical, mental or sexual abuse?

Felt alone, unloved and uncared for?

Lived with someone with mental illness or depression?

## Diet

3 day review (please list meals):

	Day 1	Day 2	Day 3
Breakfast	_____	_____	_____
Lunch	_____	_____	_____
Dinner	_____	_____	_____
Snacks	_____	_____	_____

Do you use sweeteners? Yes      No

## Physical/Mental Constitution

Weight (please check):

Low, may forget to eat. Tendency to loose weight

Moderate, Easy to gain or loose

Heavy, gain weight easily and have difficulty losing it

How do you feel about your weight currently?

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Skin (please check):

Dry rough thin

Warm, red, prone to irritation

Thick, moist, smooth

How do you feel about your skin currently?

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Hair (please check):

Dry, brittle frizzy

Thin with greying

Thick and oily

How do you feel about your hair currently?

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Joints (please check):

Thin prominent and tendency to crack

Loose and flexible

Large and padded

How do you feel about your joints currently?

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Temperament (please check):

Lively, enthusiastic, like change

Purposeful, intense. Like to convince others

Easygoing, accepting. Like to support others

Under stress I become (please check):

Anxious or worried

Irritable or aggressive

Withdrawn or reclusive

*Thank you for your diligence in filling out the questionnaire.*