Health History Questionnaire **Date: _______**

Dr. Oskar Jacunski
Board Certified Doctor of Integrative Medicine
Board Certified Doctor of Humanitarian Services
Registered Nurse
Board Certified Health Coach

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This is considered confidential. If you have anything you wish to bring to our attention, which is not asked on this form, please note it in the Comments section.

First Name ____________________ Last Name ______________________ M.I. ___________

Date of Birth ________________ Sex at Birth __________ Relationship Status_____________

Address ____

City _________________________________ State ____________ Zip ___________________

Preferred Phone #________________________ Email_________________________________

Emergency Contact (Name, Phone #, Relationship)____________________________________

Religious Preference_____________________ Occupation __________________________

HISTORY

Are you currently working? Unemployed ____ Full Time ____ Part Time ____ Retired ____

Not working ____ Student _____

Any physical restrictions? ____

Any recent hospitalizations or surgeries? ____

Have you ever had any recent shots/vaccinations?_____________________________________

Are you currently taking antibiotics? ____

What are your hobbies?____

Please check if any of these are part of your

Personal health history:

__ Abdominal pain	__ Decreased range of motion	__ Nervous tension
__ Accident	__ Depression	__ Neuropathy
__Addictions (alcohol, tobacco, caffeine)	__ Diabetes	__ Pacemakers/Defibrillator
	__ Digestive disorders	__ Seizures
__Allergies to oils/perfumes	__ Disc problems	__ Stroke
__ Arthritis	__ Fibromyalgia	__ Surgery
__ Breast augmentation	__ Headaches	__ Thyroid problems
__ Broken bones	__ Heart attack	
__ Bursitis/gout	__ HIV	__ Ulcerative colitis
__ Cancer	__ Hypertension	__ Varicose veins
__ Chest pain	__ Low-back pain	__Other
__ Currently pregnant	__ Mid-back pain	________________

Do you take any medications?

____

____

Supplements:

____

____

Name of illicit/recreational drugs used in the last month ____________________________

Number of extreme toxic exposures this year (radiation, insecticide, chemicals) to the best of your knowledge____

Diet Questions

How many meals do you eat per day? _____________ How many snacks? __________________

What foods do you usually eat per meal? ("For example")

Breakfast:____

Lunch:____

Dinner:____

What is the source of your drinking water? ____

Number of glasses of water you drink per day ____

Do you consume fruits and vegetables? How often? _______________________________________

Do you consume dairy or meat? How often? ____

Are the products you purchase organic? ____

Do you experience any digestive issues? ____

Do you smoke? Yes__ No___ (How many packs per day ____)

Do you drink? Yes__No___Number of alcoholic drinks a week _____

Number of sugar type products daily including soft drinks, ice cream, cookies, donuts, etc. ___

Do you have any environmental or food allergies? _______________________________________

Number of cups of coffee a day____

Other caffeine products daily ____

Any other relevant diet-related information? ____

Exercise (how often/duration) ____

Lifestyle (circle one): ACTIVE (daily activities)

AVERAGE (3-4 days/ week)

INACTIVE

Stress

Unresolved mental stress? Y ___ N ___

Number of street drugs used in last month ____

Is your occupation stressful? Explain. ____

____

____

Are there any stressful relationships (co-workers/friends/family)?

____

____

Please answer-using scale of 0-10

___ Interpersonal stress ____ Family Stress ____ Job or school stress ___ Stress from sickness

___Stress from desire for things to be different ____ Financial struggle

How much Personal Stress do you have in your life? (Scale 0-10) ________

(If you answer is 7 or above please answer the question below using scale of 0-10)

Please place a X if you have issues with any items below

__Problems with breathing

__Problems with bowels/bowel pattern

__How many bowel movements per day?___

__How many bowel movements per week?___

__Sleep Problems (__too much or __too little)

__Problems with sweating

__Problems urinating

__Problems with mucus (too much)

__Problems with skin (itching, rashes)

__Depression

Females only:

Have you ever used birth control pills? Yes___No___

If yes, when and how long?_______________________________

Self-Awareness Questions:

1. Do you practice any form of relaxation, meditation, prayer? Yes___ No___

   ____

2. Have you noticed any connections between your perception of stress and your physical being?

   ____

3. If you decided to change your diet/lifestyle in order to improve your life, is there someone close to you that would support your decision? Yes ___ No ___

4. Do you have a support person? If so, who? ____

5. Is there anyone in your life that would make it difficult for you to follow through on such a change?

   ____

6. What is your biggest fear or concern about your health? ______________________________

   ____

7. How long have you had this fear? ____

8. Do you feel there is an emotional connection with your current physical condition?

   ____

9. What do you think your body needs in order to heal? _________________________________

   ____

10. Are you willing to change and take control of your health and life situations? Yes____No____

11. Do you believe in God or some infinite source of power? Yes___No___

    ____

12. What is your life mantra (a belief or phrase you live by)?

____

13. What illness/issues would you like support with during the upcoming visit?

____
____
____

14. What major physical or emotional traumas have you experienced in your life?

____
____
____
____

15. List three aspects in your life that you would like to improve or change.

____
____
____
____

~~ Consent for Wellness Consultation ~~

I believe the information I have been provided is accurate. I agree to participate in the wellness consulting services provided by: Dr. Oskar Jacunski. I understand that Dr. Oskar Jacunski does not function as a physician, diagnose or treat disease, nor do his services replace the necessary services provided by a licensed physician.

Client Signature:_________________________________ Date: ________________

Print Name:___________________________________