LIFESTYLE QUESTIONS

Name:____ Date:________________

Address:____

City:________________________________ State:__________ Zip:_______ Country:______________

Home Phone: ____________________ Cell: __________________________ Fax ______________

Email:______________________________________ Referred by:____________________________

Date of Birth: M/____D/ ____Year/______ Place of Birth:_____________________ Time of Birth:_________

***Do you have a Pacemaker? yes / no**

***Are you pregnant? yes / no**

*Are you sensitive to electricity? yes / no

*Rate how you feel today on scale of 1-10: _____

*Personal stress level (1-10 max.):_____

*Your positivity level (1 negative-10 positive):_____

Number of organs removed: _____

Number of prescription drugs currently used: _____

Amount you smoke/day: _____

Number of steroid type drugs used in last year: _____

Number of metal amalgam fillings-
(Current or present during last year): ______

Number of street drugs used in last month: _____

Number of known allergies: _____

Number of emotional mental factors: _____
(Depression, anger, anxiety, worry, etc.)

Responsibility for your health (1-10 max):_____

Amount of fat in diet (20-low,30-med,40-high):_____
(Include processed foods)

Do you take vitamins daily? ________

Number of sugar type products/day: _____
(On average) Include soft drinks, ice cream etc.

Number of exercise sessions/week: _____
(15 minutes or more)

Number of alcoholic drinks weekly (average): ____

Number of cups of coffee, tea/day: _____
(Average caffeine intake)

Number of extreme toxic exposures: _____
(Radiation, insecticides, chemicals)

Number of major infections: ____
(Past and present)

Number of major injuries in past: _____
(Major car accidents, falls, etc.)

Number of glasses of water per day: _____

Are you comfortable with your weight? If not, how many lbs. over or under weight? _____

Dr. Suzanne J. Shurbet