"Get Ready, Get Set, Get Healthy!"

Capital Area Pageant Organization

Fitness and Critical Health Team

BODY WORK:

HEALTH QUESTIONNAIRE
"A wise man should consider that health is the greatest of human blessings." ***Hippocrates***
SECTION 1
How many colds do you get a year? _____
Do you have Allergies? _____
Do you have brittle fingernails? _____ Brittle, breaking hair _____
Have you ever had acne? _____ If yes, when? _____
Do you have mouth ulcers? _____
Do you have thick skin? _____ Eczema _____ Dermatitis _____
Are you having trouble focusing? _____
Do you have low blood sugar? _____ Fever blisters _____ Asthma _____
Do you have excessive cellulite? _____ Enlarged facial pores _____ Wrinkles _____
Do you forget things often? _____
If yes, how often? __ Several times a day __ Daily __ Weekly __ Rarely
Extra Notes:
_____
_____
_____

SECTION 2
How often are you depressed? _____ Irritable? _____ Suicidal? _____
Do you have ridges on your fingernails? _____ Enlarged tongue? _____ Night sweats _____
How often do you get tired? _____ Crave sugary foods? _____
How often do you have mood changes?
__ Never __ Hourly? __ Daily? __ Weekly? __ Monthly? __ Yearly?
Extra Notes:
_____
_____
_____

SECTION 3
Do you have ridges on your fingernails? _____
Do you have gas with meals? _____
Extra Notes:
_____
_____
_____

SECTION 4
Do you have gas with meals? _____ Heartburn? _____ Sour stomach after meals? _____
Do you have acid reflux? _____ Constipation? _____ Diarrhea? _____
Have you had a recurrent vaginal yeast infection? _____ Do you have bad morning breath? _____
How many bowel movements do you have each day? _____ Antibiotics? _____
Are you lactose intolerant? _____ When you pass gas, does it stink? _____
Extra Notes:
_____
_____
_____

SECTION 5
How many bowel movements do you have each day? _____
How often do you have Constipation? _____ Diarrhea? _____ Hemorrhoids _____
How would you best describe your stool? (Check all that apply.)
__ Dark brown __ Little balls __ The consistency of applesauce
__ Sandy colored __ Narrow pencil size __ Very watery
__ Most sink __ Sausage size __ The consistency of oatmeal
__ Most float __ Hot dog size __ Bright red in some stools
__ Some float and some sink
Extra Notes:
_____
_____
_____

SECTION 6
Do you bruise easily? _____
Do you have Varicose Veins _____ Keloids? _____ Hangnails _____
Mini Strokes? _____
Extra Notes:
_____
_____
_____

SECTION 7
Do you have Hot Flashes? _____ Cold feet and hands? _____ Deep bone pain? _____
Do your lips chap? _____
If so, how often? __ Daily __ Weekly __ Monthly __ Yearly
Extra Notes:
_____
_____
_____

SECTION 8
Do you grind your teeth? _____
Do you have trouble falling to sleep? _____ Sleep lightly? _____
Do you wake up all through the night? _____ Wake up tired in the morning? _____
Do you have numbness in your fingers or toes/feet during the day? _____ At night? _____
Do you have any of the following? (Check all that apply.)
__ Receding gums
__ TMJ pain
__ Heart palpitations
__ Menstrual cramps
__ Muscle cramps
__ Muscle tension across your shoulders
Extra Notes:
_____
_____
_____

SECTION 9
Have you ever had metal colored fillings? _____ How many? _____ For how long? _____
Do you have swollen ankles or feet? _____ Arthritis _____
Do you have dark spider or varicose veins? _____
How often are you tired? _____ Too tired to make it across the room _____ Take naps _____
How often do you get a headache? _____
Have you ever ingested well water? _____ If yes, when and how long? _____
Have you worked in an orchard? _____ If yes, when and how long? _____
Have you worked with metal? _____
If yes, explain. _____
If yes, when and how long? _____
Extra Notes:
_____
_____
_____

SECTION 10
How many times a week do you work into a sweat for 20 or more minutes? _____
What is your blood type? _____
Do you have swollen ankles or feet? _____

Do you have high blood pressure? _____
Do you have high cholesterol? _____
How often do you take laxatives _____
Do you have to get up and pee more than twice a night? _____
Have you have any sudden hair loss? _____ If yes, describe. _____
How stressful do you consider your life?
__ Not stressful __ Rarely stressful __ Sometimes stressful __ Usually stressful __ Always stressful
Have you had decrease or lack of libido? _____ If yes, describe. _____
Do you have hot flashes? _____ If so, how often? _____
Extra Notes:
_____
_____
_____

SECTION 11
Have you had any recent falls? _____
Do you regularly have headaches? _____ Sinus problems? _____ Incontinence?_____
Do you have pain in any of the following areas? (Check all that apply.)
__ Hip(s)
__ Leg(s)
__ Joint(s)
__ Neck
Extra Notes:
_____
_____
_____

CHECK ALL CLINICAL DIAGNOSIS:
__ A.L.S. __ Alzheimer's __ Anemia __ Angina __ Arteriosclerosis __ Arthritis __ Bradycardia __ Bursitis __ Candidacies, systemic __ Candidacies, vaginal __ Cancer, type _____
__ Cataracts __ Colitis __ Crohn's disease __ Cystic fibrosis __ Dementia __ Diabetes __ Disc degeneration __ Diverticulosis __ Dyslexia __ Emphysema __ Endometriosis __ Epilepsy
__ Frequent urination __ Fibrocystic disease __ Fibromyalgia __ Gall stones __ Gastritis
__ Glaucoma __ Gout __ Headaches __ hepatitis ___Hypercholesterolemia __ Hyperadrenia
__ Hyperlipidemia __ Hypertension __ Hyperthyroidism __ Hypoadrenia __ Hypothyroidism
__ Liver dysfunction __ Liver cancer __ Lupus __ Migraines __ Hyperglycemia __ Hypoglycemia __ Infections (bacterial) __ Irritable bowel syndrome __ Mononucleosis __ Multiple sclerosis
__ Muscular dystrophy __ Osteoporosis __ Ovarian cysts __ Paget's disease
__ Parkinson's __ PMS __ Renal disease __ Scleroderma __ Stones, calcium oxalate __ Stones, phosphate stones __ Stroke __ Tachycardia __ Tourette's syndrome __ Tumors, benign breast __ Tumors, malignant breast __ Ulcers – gastric __ Ulcers – duodenal __ Viruses __ Hemachromatosis __ Bladder disturbances Explain _ Other

----------FOR OFFICE USE ONLY ----------
Coach Assigned: _____ Health Priorities (1) _____ (2) _____ (3) _____
Prevention/Health Protocol 90 Basic Secret Sauce: (1) _____ (2) _____ (3)_____
Date review every week from start date:

Client's Name: _____ Address: _____
Phone Number: _____
Health Advocate Assigned: _____ Primary Focus: Weight Health

Evaluator Notes: _____
_____
_____
_____

Client's product preference: _____
_____
_____