Health Questionnaire

Thank you for choosing Intuitive Health Restoration where you will discover much about your health and how your body functions. We welcome any questions you may have during the course of your participation.

In order for us to fully understand your circumstances, these forms **Must** be completed in their entirely before your visit. You may use another sheet of paper if you need more room to write. If the paperwork is not completed, your initial visit will need to be rescheduled. Thank you for understanding and for your corporation.

Name:_____**date:**_____

Street:_____

City:_____**State:**_____**Zip:**_____

Home Phone:_____**Cell Phone:**_____

Email Address:_____

Birthday:_____**Age:**_____

An important question for you - your thoughts will help me understand where you are now, where you would like to be, your goals, and your purpose of this visit:

Imagine feeling fully alive - in spirit, soul, and body. What would that look like for you?

What are your top 4 health concerns, listed in order of importance?

1.

2.

Kelly Klann RN, CCWFN
580 Forest Ave Suite 9B,
Plymouth Michigan 48170
313.570.9114
kelly@ihealthrestorion.com

3.

4.

Relaxation:

Do you set aside time daily to meditate/pray/sit quietly?

Do you set time in your day or week to rest and relax?

How often do you take a vacation?

Energy:

How is your energy throughout the day?

Do you typically have a low energy time during the day?_____ If so, When?_____

Miscellaneous:

Are you under the care of any health care provider? If so, for what diagnosis or reason?

List any chronic illnesses that you have ever had and currently have:

List any surgeries you have ever had:

List any scars that you have:

List any known allergies:

How often do you exercise in a week? What activities do you do?

How does your body heal from infections?

Childhood:

Please describe your birth:(C-section, induced, forceps, suction, etc…)

Where you breast or bottle fed?

Where did you grow up?

List any childhood illnesses that you had:

List any vaccinations you had as a child and as an adult:

Hydration:

How much water do you drink in a day?_____

How much of these fluids do you consume in a day:
Alcohol_____
Soda_____
Coffee_____
Tea_____
Dairy_____
Juice_____
Energy Drinks_____
Other_____

Kelly Klann RN, CCWFN
580 Forest Ave Suite 9B,
Plymouth Michigan 48170
313.570.9114
kelly@ihealthrestorion.com

Diet:
Briefly describe your diet (types of food, # of meals and snacks in a day):

Do you regularly skip meals in a day?

Food Allergies or sensitivities:

Dairy_____
Wheat/Gluten_____
Eggs_____
Nuts_____
Other_____

Please list any food cravings that you have: (salt or sugar):

Digestion:
Adequate
Poor
Acid reflux
Burp often
Bloating
Burning or pain in stomach
Gas
Other:_____

Mental:
Brain fog
Depression
Anxiety
ADHD
Panic Attacks
Other:_____

Sleep:
Restful
Sleep through the night
Restless
Hard to get to sleep
Wake up often _____ particular time that you wake up during the night?

Kelly Klann RN, CCWFN 580 Forest Ave Suite 9B, Plymouth Michigan 48170 313.570.9114 kelly@ihealthrestorion.com

Get up during the night
Bad dreams
Other:_____

How many hours do you sleep?_____

Sex:
Describe any problems with sexual function/activity:

Skin:
Describe any skin issues:

Stress:
Please describe any emotional crises in the past year: (Death, divorce, job loss, change in family, pregnancy, school, friends, change in residences)

On a scale of 1 to 10 (10 = highest), what would your stress levels be in the following areas?

In general?_____
Relationships? Family_____
Friends_____
Co-workers_____
Environment?_____
Health?_____
Work?_____
Spiritual?_____

Bowel Movements: Please checkable that apply

Frequency	1-3 bowel movements per day		Fewer than one bowel movement per day	
Transit Time	Bowels are easily moved		Pain, Strain, explosive gas, or cramping	
Size/Shape	Stools that are fairly large in diameter(the diameter of a colonies roughly 2-3 inches)		Skinny stools	

Texture	Stools that hold together, Smooth on the outside, similar to the shape of a colon		Rabbit pellets, diarrhea, chunky or lumpy stools (often can be a sign of dehydration of incomplete elimination)	
Color	Brown in color		Green, clay colored, red, black, or any color other than brown	
Composition	Bobbing stools		Sinking or floating stools(this can be an indication of improper digestion of certain nutrients)	
Odor	very little odor		Bowel movements that have an overpowering stench (another indication of incomplete or poor digestion)	

Pain:

Do you have pain anywhere? If yes, where and how often? When did it start?

On a scale of 0 (no pain) to 10 (worst pain you can imagine), how bad is it?

Supplements:

Please list any supplements that you are currently taking:

Medications:

Please list any medication that you are currently taking:

Please list anything else that you want me to know about you:

Please give me an idea of a typical day with food: (breakfast, lunch, dinner)

Please list your family history: like cancer, heart disease, diabetes, anything else?

Are they alive or deceased?

Kelly Klann RN, CCWFN
580 Forest Ave Suite 9B,
Plymouth Michigan 48170
313.570.9114
kelly@ihealthrestorion.com