Date _____

TREVOR'S LOVE, INC.
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CLIENT INFORMATION

Name_____ Ht. _____ Wt. _____ Age _____ M or F (Circle one)

Address _____ City _____ State_____ Zip _____

D.O.B. _____Email Address_____

Home Phone _____ Work Phone _____ Fax _____

Employment _____ Family Physician _____Cardiologist_____

HEALTH QUESTIONNAIRE
A SELF-ASSESSMENT

What is Your Body Telling You?

Yes	No	*Thyroid/Parathyroid (Glandular System)*
○ yes	○ no	Are you overweight?
○ yes	○ no	Do you get cold hands and feet?
○ yes	○ no	Do you have hair loss or are you bald or going bald?
○ yes	○ no	Is it easy to put on weight and hard to lose it?
○ yes	○ no	Are your fingernails ridged, brittle or weak? (circle one)
○ yes	○ no	Do you have varicose or spider veins?
○ yes	○ no	Do you, or have you had hemorrhoids or prolapsed organs? (circle one)
○ yes	○ no	Do you get cramping in your muscles?
○ strong	○ weak	Is your bladder strong or weak?
○ yes	○ no	Do you have an irregular heartbeat?
○ yes	○ no	Do you have Mitral Valve Prolapse (*Heart Murmur*)?
○ yes	○ no	Do you get headaches or migraines?
○ yes	○ no	Have you ever had a hernia?
○ yes	○ no	Have you ever had an aneurysm?
○ yes	○ no	Do you have osteoporosis?
○ yes	○ no	Do you have scoliosis?
○ yes	○ no	Do you get irritable easily?

Yes	No	***Thyroid/Parathyroid (Glandular System Continued)***
○ yes	○ no	Do you have low energy levels?
○ yes	○ no	Do you suffer from symptoms of depression?
○ yes	○ no	Did you score low on your bone density tests?
○ yes	○ no	Do your tests come back showing low Calcium levels?
○ yes	○ no	Do you have, or have you ever had, a goiter?
○ yes	○ no	Do you have spine deterioration, herniated discs, or bone spurs?
○ yes	○ no	Have you been diagnosed with Hashimoto or Reidel disease? (*Or any family member?*)
○ a lot	○ little	Do you sweat profusely or hardly at all?

Yes	No	***Adrenal Glands (Glandular System)***
		Medulla (Adrenal)
○ yes	○ no	Do you have M.S., Parkinson's or Palsy? (circle one)
○ yes	○ no	Do you have *anxiety attacks*, or feel *overly anxious*?
○ yes	○ no	Do you feel excessive *shyness*, or *inferior* to others?
○ yes	○ no	Do you have High or Low Blood Pressure? (circle one) Systolic_____ Diastolic_____
○ yes	○ no	Do you have tremors, nervous legs, etc.?
○ yes	○ no	Do you have tinnitis (*ringing in the ears*)?
○ yes	○ no	Do you have S.O.B. (*shortness of breath*) or is it hard to take a deep breath?
○ yes	○ no	Do you have heart arrhythmias?
○ yes	○ no	Do you have a hard time sleeping or insomnia?
○ yes	○ no	Do you have Chronic Fatigue Syndrome?
○ yes	○ no	
○ yes	○ no	Have you ever been diagnosed with Addison's Disease or Congenital Adrenal Hyperplasia? (circle one)
		Cortex (*Adrenal*)
○ yes	○ no	Do you have elevated blood cholesterol levels?
○ yes	○ no	Do you have lower back weakness?
○ yes	○ no	Do you have, or have you had, sciatica?
○ yes	○ no	Do you have arthritis, bursitis, or any inflammatory issues?
○ yes	○ no	Do you have any "itis's (*inflammatory conditions*)? *Which?* _____ *(arthritis, bursitis, rheumatoid arthritis, colitis, enteritis, phlebitis, neuritis, etc.)*
○ yes	○ no	Low steroids or cortisol levels?

Yes	No	***Female Only***
○ yes	○ no	Are your menstruation's irregular?
○ yes	○ no	Do you get excessive bleeding during menstruation?
○ yes	○ no	Do you have or have you had ovarian cysts?
○ yes	○ no	Do you have or have you had fibroids?
○ yes	○ no	Do you have or have you had endometriosis or A-typical cells?
○ yes	○ no	Do you have or have you had fibrocystic breasts?
○ yes	○ no	Do you have fibromyalgia or scleroderma?
○ yes	○ no	Do you get sore breasts, especially during menstruation?
○ high	○ low	Do you have a low or excessive sex drive?
○ yes	○ no	Have you had a hysterectomy? When_____? *Partial* _____ *Complete* _____
○ yes	○ no	Did they take any other organs out at the same time? *(c.a. gallbladder)*
○ yes	○ no	Have you had a D & C?
○ yes	○ no	Have you had a miscarriage?
○ yes	○ no	Have you had difficulty conceiving children?
		Have you been on Birth Control Pills? How Long_____?

Yes	No	***Male Only***
○ yes	○ no	Do you have prostatitis (*frequent urination esp. at night*)? If yes, how often?
○ yes	○ no	Do you have prostate cancer? PSA count's _____
○ yes	○ no	Do you have testicular hypertrophy (*enlargement*)?
○ yes	○ no	Do you have a low or excessive sex drive?
○ yes	○ no	Do you have erection problems?
○ yes	○ no	Do you have premature ejaculation?
		Other

Yes	No	***Pancreas***
○ yes	○ no	Do you get gas after you eat?
○ yes	○ no	Do you feel your foods just sitting in your stomach?
○ yes	○ no	Do you have Acid Reflux?
○ yes	○ no	Do you see any undigested foods in your stools?
○ yes	○ no	Do you have hypoglycemia (*Low Blood Sugar*)?
○ yes	○ no	Do you have Diabetes (*High Blood Sugar*)? Type I ___ or Type II ___ (*late onset*)

Yes	No	***Pancreas (Continued)***
○ yes	○ no	Are you thin and have a hard time putting on weight?
○ yes	○ no	Do you have gastritis or enteritis?
○ yes	○ no	Do your foods pass right through you (*diarrhea*)?
○ yes	○ no	Do you have moles on your body? (Adrenal & Pancreatic weakness)

Yes	No	***Gastro-Intestinal Tract***
○ yes	○ no	Is your tongue coated (*white, yellow, green or brown*), especially in the morning?
○ yes	○ no	Do you have a Hiatus Hernia?
○ yes	○ no	Do you have Gastritis?
○ yes	○ no	Do you have Enteritis?
○ yes	○ no	Do you have Colitis?
○ yes	○ no	Do you have Diverticulitis?
○ yes	○ no	Do you get or have Diarrhea?
○ yes	○ no	Do you get or have Constipation?
___ Day	___Week	How many times do you have a Bowel Movement per day or week?
○ yes	○ no	Have you ever had stomach or intestinal ulcers?
○ yes	○ no	Do you or have you ever had any type of gastro-intestinal cancers: stomach, colon, rectal, etc. Explain:
○ yes	○ no	Do you have Crohn's Disease?
○ yes	○ no	Do you have "gas" problems?
○ yes	○ no	Other GI problems:

Yes	No	***Liver/Gallbladder/Blood***
○ yes	○ no	Do you have a problem digesting fats?
○ yes	○ no	Do fats or dairy foods cause bloating and/or pain in the stomach area?
○ yes	○ no	Are your stools white or very light brown in color?
○ yes	○ no	Do you get pain in the middle of your back (*especially after eating*)?
○ yes	○ no	Do you get pain behind the right, lower rib area?
○ yes	○ no	Do you have "liver" or brown spots on your skin? (*not freckles*)
○ yes	○ no	Do you have any skin pigmentation changes?
○ yes	○ no	Do you have skin problems? If so, what type?
○ yes	○ no	Are you or have you ever been anemic?
○ yes	○ no	Do you have, or have you ever had, hepatitis? A___, B___, C___.

Yes	No	***Heart & Circulation***
○ yes	○ no	Do you have any gray hair?
○ yes	○ no	Do you have a hard time remembering things?
○ yes	○ no	Do your legs get tired or cramp after you walk?
○ yes	○ no	Do you bruise easily?
○ yes	○ no	Do you get chest pains or angina?
○ yes	○ no	Have you ever had a heart attack (*Myocardial Infarction*)?
○ yes	○ no	Have you ever had open-heart surgery?
○ yes	○ no	Do you have heart arrhythmia's? What kind?
○ yes	○ no	Do you have a heart murmur or Mitral Valve Prolapse?
○ yes	○ no	Do you ever feel pressure on your chest?
○ yes	○ no	Do you get "prickly" pains anywhere, especially in the heart area? Where?_____
○ yes	○ no	Do you have, or have you ever had High Blood Pressure?
○ yes	○ no	Do you have a Pacemaker or Stints? (circle one)

Yes	No	***Skin***
○ yes	○ no	Do you get or have skin rashes?
○ yes	○ no	Do you get skin blemishes?
○ yes	○ no	Do you have Eczema or Dermatitis?
○ yes	○ no	Do you have Psoriasis?
○ yes	○ no	Do you itch anywhere? Where?
○ yes	○ no	Is your skin dry?
○ yes	○ no	Is your skin excessively oily?
○ yes	○ no	Do you get or have dandruff?

Yes	No	***Lymphatic System***
○ yes	○ no	Have you ever had Lymph Nodes removed?
○ yes	○ no	Do you ever get colds or flu-like symptoms?
○ yes	○ no	Do you have sinus problems?
○ yes	○ no	Do you have or get sore throats?
○ yes	○ no	Do you have swollen lymph nodes?
○ yes	○ no	Do you have or have you had tumors? What type? *Fatty*_____ *Benign*_____ *Malignant* _____ Where?_____

Yes	No	*Lymphatic System (continued)*
○ yes	○ no	Do you have a low platelet count (blood)?
○ yes	○ no	Is your immune system weak or sluggish?
○ yes	○ no	Have you had appendicitis or an appendectomy? When?
○ yes	○ no	Do you get boils, pimples, cysts, etc.?
○ yes	○ no	Do you get regular exercise? How many times per week? _____
○ yes	○ no	Have you ever had abscesses?
○ yes	○ no	Have you ever had toxemia?
○ yes	○ no	Do you have, or have you had, cellulitis?
○ yes	○ no	Have you ever had gout?
○ yes	○ no	Do you get blurred vision?
○ yes	○ no	Do you have mucus in your eyes when you wake up in the morning?
○ yes	○ no	Do you snore?
○ yes	○ no	Do you have sleep apnea?
○ yes	○ no	Have you had your tonsils out? What age? _____

Yes	No	*Kidneys & Bladder*
○ yes	○ no	Have you ever had a urinary tract infection (*UTI's*)?
○ yes	○ no	Have you ever had "burning" upon urination?
○ yes	○ no	Do you have problems holding your bladder (*parathyroid*)?
○ yes	○ no	Have you ever had kidney stones?
○ yes	○ no	Do you have bags under your eyes (*esp. in the morning*)?
○ yes	○ no	Is your urine flow restricted?
○ yes	○ no	Do you get cramping or pain on either side of your mid-to-lower back?
○ yes	○ no	Do you or did you ever have nephritis?
○ yes	○ no	Do you or did you ever have cystitis?

Yes	No	*Lungs*
○ yes	○ no	Do you get or have (or have had) bronchitis?
○ yes	○ no	Do you get or have (or have had) emphysema?
○ yes	○ no	Do you get or have (or have had) asthma?
○ yes	○ no	Do you get or have (or have had) C.O.P.D?
○ yes	○ no	Are you on inhalers or nebulizers? How often? What type?
		Your oxygen saturation level is _____.
○ yes	○ no	Do you get pain when you breathe?
○ yes	○ no	Do you get pain when you take a deep breath?
○ yes	○ no	Did you ever or do you have lung cancer?

Yes	No	*Lungs (Continued)*
○ yes	○ no	Do you have a collapsed lung?
○ yes	○ no	Are you a smoker? How often?
○ yes	○ no	Have you ever had pneumonia?
○ yes	○ no	Have you ever worked around toxic chemicals, in coal mines or around asbestos?
○ yes	○ no	Do you cough a lot?
○ yes	○ no	Do you get any mucus when you cough?
		What color is the mucus? (clear, yellow, green, brown or black?)

Environmental Toxins

Have you been vaccinated? Or shots for traveling to foreign countries?	○ yes	○ no
Regular Flue Shots?	○ yes	○ no
Do you have Mercury Amalgams?	○ yes	○ no
Any exposure to nuclear wastes or by-products, heavy metals, or chemicals?	○ yes	○ no
Have you had any radiation or chemotherapy? (circle one) If so, how many treatments?_____		

What are your major health complaints or concerns?

Please list any conditions or symptoms that this questionnaire has not covered or asked you.

Past Surgeries

Please list any past surgeries you have had (*e.g. tonsils removed, hysterectomies, open heart surgery, etc.)*

Surgery	***Year***

Chemical Medications

Please list any chemical medications that you are presently taking:

Medication	***Reason:***

Natural Supplements

Please list any natural supplements you are currently taking:

Supplements	***Vitamins & Minerals***

Allergies

Please list anything that you are all allergic to:

Allergies to....

Genetic History *(what health issues did they have…)*

Mom:
Dad:
(Maternal) Grandfather:
(Maternal) Grandmother:
(Paternal) Grandfather:
(Paternal) Grandmother:
Sister:
Sister:
Brother:
Brother: