RACHEL SILVES

Health Questionnaire

Name: _____ Today's Date: _____
Address: _____
City: _____ State: _____Zip: _____
Email address: _____ Skype contact (if applicable): _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
What numbers are best for detailed messages? _____
What is your preferred method of contact? _____
How did you find out about Rachel Silves? _____
Would you like to receive news from Rachel Silves (include email)? _____
Gender Identity_____ DOB: _____ Place of Birth: _____
Genetic background: ☐ African American ☐ Native American ☐ Mediterranean ☐ Asian
☐ Caucasian ☐ Northern European ☐ Other _____

What would you like help with at this time?

_____
_____
_____
_____
_____

Please list your health concerns: **How long have you had these conditions?**

1._____ _____
2._____ _____
3._____ _____
4._____ _____
5. _____ _____

Name and contact information for Primary Physician: _____
_____
Please list other practitioners that you are seeing: _____
_____

Family History:

Relationship	Alive/Deceased	Present Health or Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brothers		
Sisters		
Children		

Comments on family health history: _____

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Medications and Supplements: *Please list all **prescription medications** and **nutritional supplements, herbs** you are currently taking. Use a separate sheet if needed.*

Medications	Name	Dosage	Frequency	Length of time	Purpose

Supplements	Name/Brand	Dosage	Frequency	Length of time	Purpose

Allergies:_____
_____

Have you used any of the following medication in the past and if so, provide dates: Prednisone, acid blocking drugs, Tylenol, NSAIDS, and antibiotics_____
_____

List major traumas, major or minor surgeries, and hospitalizations? _____
_____
_____

Are you pregnant? Yes_____ No_____ Are you breastfeeding? Yes_____ No_____

Do you have a history of alcohol/substance dependence? Yes_____ No____ Is there any reason why you could not take remedies made in alcohol? Yes_____ No_____

Do you have any infectious diseases that you know of? Yes_____ No_____ If yes please list_____
_____

Physical Activity and Lifestyle

What kind of physical activities do you do? _____
Are you satisfied with your energy level? _____
Are there any problems/limitations that inhibit your physical activity? _____

Activity	Type(s)	Days per week	Duration
Stretching/Yoga			
Strength Training			
Aerobic/Cardio			
Sedentary Lifestyle			

What do you do for relaxation? _____

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How many hours of sleep do you get a night/day? _____ Do you sleep well? _____
Please rate the following on a scale of 1-10 (10 being best) and write in any comments:
Sleep:_____
Energy Level:_____

Relationship Status: _____ Divorced: _____ Widowed:_____
Current Occupation: _____How many years? _____ Hours per week? _____
Do you like your work? _____
Passions/Interests? _____

On a scale of 1-10, with 1 being low and 10 being high, how stressful is your:
Work: _____ Current health status: _____ Social/family situation: _____ Life in general:_____

PERSONAL STRESS				
	___	I worry a great deal	___	I feel angry often
	___	I feel lonely	___	I cry easily
	___	I am bored with my life	___	I am ill often
	___	I feel a great deal of frustration	___	I often feel depressed
	___	I think a lot about dying		
	___	I feel fearful or afraid		
	___	I feel anxious		

Past significant life events:_____
_____
What do you believe you can do to make a difference in your current health? _____
_____

Environmental information: How often are you exposed to any of the following?
*Insert a number and circle **day** or **week***

Cigarette smoke: _____ x d / wk	How many mercury amalgams do you have? _____
Wood stove: ____ x d / wk	Recreational drugs ____ x d / wk
Perfumes/hair dyes: ____ x d / wk	Pet dander _____ x d / wk
Car exhaust: ____ x d / wk	Mold _____ x d / wk
Pesticides: _____ x d / wk	Cleaning products _____ x d / wk
Dry cleaned clothes _____ x d / wk	Teflon or aluminum pans ____ x d / wk
Bottled water _____ x d / wk	Photo developing/harsh chemicals: _____ x d / wk
Hand sanitizer _____x d / wk	Cosmetics, creams, lotions _____ x d / wk

Nutrition
Please list **food** allergies: _____
Please list **environmental** allergies: _____
Please list any special dietary restrictions/habits you have: _____
_____
What foods do you crave if anything? _____
What are your favorite foods? _____
Please describe any changes you have made to your diet to improve your health? _____
_____
How would you describe your relationship to food? _____
_____
On a scale of 1-10; how healthful and nourishing do you feel your diet is currently?_____

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Height:_____ Weight: _____ Ideal Weight: _____
Highest Adult weight: _____ Year: _____ Lowest Adult Weight: _____ Year: _____

Food Frequency: How often do you eat or do the following? *Insert a number and circle **day** or **week***

Meals per day: _____ Approx. times: B_____ L_____ D_____
Snacks per day: _____ Approx. times: B_____ L_____ D_____
Water _____ ounces per day. Other Beverages:_____
Prepare meals at home: _____ x d / wk
Alcoholic Drinks: _____ x d / wk Coffee:_____ x d / wk
Eat fast or on the run: _____ x d / wk

List examples of what you typically eat for Breakfast, Lunch, and Dinner. List what you eat for Breakfast, Lunch, and Dinner when you are at your best health. List what you eat for Breakfast, Lunch, and Dinner when you are in a hurry or stressed.

Typical Breakfast:_____
_____
Typical Lunch:_____
_____
Typical Dinner:_____
_____
Best Breakfast:_____
_____
Best Lunch:_____
_____
Best Dinner:_____
_____
Stressed Breakfast:_____
_____
Stressed Lunch:_____
_____
Stressed Dinner:_____
_____

3-Day Food Journal

1) Please write down all food and drink, including water
2) Record information as soon as possible after the food has been consumed
3) Do not change your eating behavior, the purpose of this food record is to analyze your current eating habits.
4) Describe the food or beverage consumed. e.g., milk - what kind? (soy, almond, whole, 2%, or nonfat, etc.); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
5) Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.

Day 1	Day 2	Day 3

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Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack
Dinner	Dinner	Dinner
Snack	Snack	Snack
Mood/Energy	Mood/Energy	Mood/Energy

Elimination Habits:

How frequently do your bowels move?_____

Consistency (hard to pass, loose, formed, etc.)_____

_____

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Symptom Review: Please check symptoms noticed in the past year. Any major problems that you had previously, but no longer have, mark with a "P"

Pain:

Do you have any pain and if so please describe: _____

_____

_____

Area:	Pain Level (1-10; 10 being worst)	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

UPPER GI

___	Nausea in evenings	___	Nausea in mornings
___	Indigestion after eating	___	Excess salivation
___	Duodenal ulcer	___	Stomach ulcer
___	Foul burps	___	Strong, demanding hunger
___	Butterflies in stomach	___	Dental cavities
___	Skips breakfast	___	Gum problems
___	Often don't' finish meals		
___	Often eat to calm down		
___	Frequent use of alcohol		
___	Poor appetite		
___	Bitter taste or bad breath in morning		
___	Acid indigestion at night		
___	Mouth or cold sores, or receding gums		
___	Mouth frequently too dry, or difficulty swallowing		

LOWER GI

___	Tongue often coated	___	Stools loose with gas
___	Constipation, need for laxatives	___	Digestion unusually rapid
___	Light colored, hard stools	___	Loose stools when tired/stressed
___	Intestines often bloated, or gassy	___	Dark, soft stools
___	Constipation with hemorrhoids or pain	___	Quick defecation after eating
___	Constipation with hard, marbly stools		
___	Alternating constipation / diarrhea		

LIVER

___	Dry, even scaly skin	___	Moist, sometimes oily skin
___	Hay fever or asthma	___	Hives from food or drugs
___	Craves fruit or sweet	___	Craves protein, fats
___	Trouble digesting fats	___	Fever with sweat when sick
___	Acne on face AND buttocks		
___	Seem to have low blood sugar		
___	Had hepatitis in past		
___	Use of alcohol or chemicals/solvents		
___	Psoriasis, eczema, dermatitis		

RENAL & URINARY

___	Standing quickly causes faintness or dizziness	___	Standing quickly makes pulse roar in ears
___	Flushing or blushing of the skin	___	Water retention
___	Frequent urinary tract infections	___	Urine usually dark
___	Frequent thirst	___	Inability to hold urine
___	Craving for salt	___	Infrequent urination, copious urine
___	Urine always light colored		
___	Dull ache or dribble after urination		
___	Kidney stones		
___	Feeling of urgent urination, small amounts		

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___ Mucus in urine

CV & LYMPH

___	Fast, light pulse	___	Slow, strong pulse
___	Cold bodied	___	Frequent physical activity
___	Feels dizzy or faint	___	Warm bodied
___	Hands cold, clammy or dry	___	Hands warm, sweaty
___	High blood pressure	___	Palpitations
___	Injuries/Colds heal slowly	___	Low blood pressure
___	Cold hands and feet	___	Injuries/Colds heal quickly
___	Chest pain	___	Irregular heart beat
___	Fainting	___	Swelling of hands or feet
___	Easy bruising	___	Varicose veins or hemorrhoids
___	Enlarged lymph nodes	___	Anemia

MALE REPRO

___ Difficult maintaining erection when you feel in the mood _____ Number of times of urination at night

___ Benign prostatic hypertrophy

___ Pain or ache after orgasm

Are you sexually active? _____

FEMALE REPRODUCTIVE

__	Cycle more than 28 days	___	History of yeast infections
__	Miss some periods	___	Pain with intercourse
__	Menses slow starting with cramps	___	Constipation before, loose stools after menses starts
__	Menstruation longer than 7 days	___	Always hungry before menses
__	Abnormal Pap Smear; date _____	___	Breast tender before menses
__	Cycle less than 28 days	___	Palpitations before menses
__	Water retention before menses	___	**Number of Pregnancies (including miscarriages, terminations and live births)**
__	Difficulty conceiving	___	**Any chance you may be or may try to get pregnant**

Date of Last Menses_____ Length of cycle:_____

Flow: ____Light _____ Moderate _____ Heavy_____ Color of blood_____ Clots? Y / N

Other menstrual symptoms_____

_____

Date of last Pap:_____ Result of last Pap:_____

Are you sexually active? _____Birth Control Method _____

RESPIRATORY

___	Shortness of breath when standing or walking	___	Easy coughing of mucus
___	Tobacco smoker	___	Sometimes hyperventilates
___	Difficulty swallowing	___	Asthma
___	Difficulty coughing up mucus	___	Frequent coughs
___	Rapid, shallow breather	___	
___	Sometimes wake up choking or gasping for breath		
___	Yawns frequently		
___	Frequent chest colds		

EAR, NOSE & THROAT

___	Cataracts	___	Poor hearing
___	Glaucoma	___	Ringing in the ears
___	Eyes get red or inflamed	___	Ear Infections
___	Spots in front of eyes	___	Sore throats
___	Blurry vision	___	Grinding teeth
___	Earaches	___	Sinus congestion
___	Nose bleeds	___	Canker sores
___	Clicking jaw	___	Cold sores
___	Mucous in throat	___	Facial Pain

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MUCUS & SKIN	___	Dry scalp or hair	___	Oily scalp or hair
	___	Lips often dry and chapped	___	Sweat freely with strong scent
		Sores, cracks, fissures in mouth, vagina or anus		
	___	Food causes distress as it passes through	___	Oily skin, facial acne
	___	Skin eruptions are deep, not coming to a head	___	Rashes
	___	Cracks, fissures on heel, elbow, feet, poorly healing	____	Itching

MUSCULOKELETAL	___	Neck pain	___	Muscle twitches
	___	Muscle pain	___	Muscle cramps
	___	Upper back pain	___	Stomach ulcer
	___	Lower back pain	___	Strong, demanding hunger
	___	Stiffness		
	___	Muscle weakness		
	___	Reduced range of motion		
	___	Often eat to calm down		
	___	Frequent use of alcohol		
	___	Poor appetite		
	___	Bitter taste or bad breath in morning		
	___	Acid indigestion at night		
	___	Mouth or cold sores, or receding gums		
	___	Mouth frequently too dry, or difficulty swallowing		

NERVOUS	___	Poor sleep	___	Tingling or pins/needles feeling
	___	Headaches	___	Numbness feeling somewhere
	___	Tremors	___	Lack of coordination or balance
	___	Lack of sensation somewhere	___	Difficulty concentrating
	___	Seizures		
	___	Migraine		

GENERAL	__	Fevers	__	
	__	Chills	__	Likes depressants
	__	Night sweats	__	Likes stimulants
	__	Fatigue	__	Nails split, brittle
	__	Can't get started without coffee	__	Nails weak, ridges
	__	Chronic fatigue, depression	__	Pollution heavy in environment
	__	Can't gain weight	__	Pulse speeds up after meals
	__	Can't lose weight	__	Sensitive to cold weather
	__	Highly emotional	__	Sensitive to hot weather
	__	Highly controlled	__	Sensitive to high humidity
	__	Increase in weight (recent)	__	Sensitive to low humidity
	__	Sexual desire decreased	__	Stuffy nose during the day
	__	Sexual desire increased	__	Stuffy nose in evening or night
	__	Awakens, can't go back to sleep	__	
	__	Bad dreams	__	
	__		__	

Waiver of Liability:

I, the undersigned, hereby confirm that I am consulting with Rachel Silves, of my own free will. I understand that Rachel Silves is not a licensed health professional and that there will be no diagnosis made, nor prescription given. I understand that the above-named health coach will offer an assessment of my general health and may make dietary and herbal recommendations. I understand the importance of frequent monitoring to revise the treatment protocol as the symptom picture changes.

Signature _____ Date _____