Health and Lifestyle Questionnaire

Confidentiality Notice:
All information provided is strictly confidential and used solely to support your holistic wellness assessment and Bio-Well energy analysis.

Name:_____**Email:**_____
Gender: ☐ Male ☐ Female

Please circle or check all conditions or symptoms that apply.

General Health:

ADD/ADHD / Hyperactivity • Depression • Anxiety • Mood Swings • Fibromyalgia • Migraines • Autism/Asperger's • Memory Loss (☐ Short-Term ☐ Long-Term)

Physical Symptoms:

Do you frequently feel:
☐ Hot ☐ Cold ☐ Fatigued ☐ Sweaty (☐ Day ☐ Night)

Urinary symptoms:
☐ Frequent urination ☐ Incontinence ☐ Urgency ☐ Pain with urination

Digestive symptoms:
☐ Stomach ache ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Irritable bowel ☐ Bloating ☐ Gas ☐ Blood in stool ☐ Diarrhea ☐ Constipation (less than 1 bowel movement per day)

Skin and nails:
☐ Brittle nails ☐ Acne ☐ Itchy/blotchy skin

Food allergies or sensitivities (please list): _____

Do you experience fatigue or discomfort after eating any of the following?
☐ Milk ☐ Wheat ☐ Corn ☐ Eggs ☐ Soy ☐ Sugar ☐ Peppers ☐ Other: _____

Weight changes: ☐ Gain ☐ Loss

History of blood sugar imbalance? ☐ Yes ☐ No
Diagnosed with Diabetes or Hypoglycemia? ☐ Yes ☐ No

Average energy level during the day: _____

***Medical History*:**

☐ Cancer ☐ High Blood Pressure ☐ High Cholesterol ☐ Overweight
☐ Diabetes / Insulin Resistance ☐ Irritable Bowel Syndrome ☐ Parkinson's Disease
☐ Osteoporosis ☐ Thyroid Disorder ☐ Overactive Bladder ☐ Addiction / Compulsion

Other diagnosed conditions: _____

Surgeries (history or scheduled):_____

Allergies: _____

Current medications or supplements: _____

***Lifestyle*:**

Do you exercise? ☐ Yes ☐ No
If yes, how often? _____ (times per ☐ day ☐ week ☐ month)
Are you a professional athlete? ☐ Yes ☐ No
If yes, what sport? _____

***Sleep Patterns*:**

Bedtime: _____ Wake time: _____
Difficulty falling asleep? ☐ Yes ☐ No
Number of awakenings per night: _____
Upon waking, you feel: ☐ Rested ☐ Tired
Do you have vivid dreams? ☐ Yes ☐ No
Do you experience nightmares? ☐ Yes ☐ No

***Female Section*:**

Hormonal Symptoms:
☐ Hot flashes ☐ Yeast infections ☐ Spotting between periods ☐ Heavy bleeding
☐ Bladder infections ☐ Pain during intercourse ☐ Vaginal infections ☐ Vaginal discharge
☐ Change in libido ☐ Sexually transmitted disease ☐ Frequent headaches

Menstrual History:
Have you had a hysterectomy? ☐ Yes ☐ No If yes, date: _____
If yes, do you still have your ovaries? ☐ Yes ☐ No
Date of last menstrual period: _____
Cycle regular? ☐ Yes ☐ No Birth control use? ☐ Yes ☐ No

***Male Section*:**

☐ Bladder infections ☐ Discharge ☐ Erectile problems ☐ Impotence
☐ Changes in libido ☐ Difficulty starting/stopping urination ☐ Prostatitis ☐ Prostate cancer
☐ Excessive sweating ☐ Sexually transmitted disease