Integrative Health and Fitness

Robert Guiel, M.S., A.C.N. – 1029 North Road, Westfield, MA 01085 – (413) 519-7166

Health History Questionnaire

Date of 1st visit: _____/_____/_____

Name:	Date of Birth: Age:
Address:	City:
State: Zip:	Phone: (home) (cell)
☐Single ☐Partnered ☐Married ☐Separated	E-mail:
Occupation:	
Employer:	

How did you hear about us? _____

Has any other family member already been a client here? Y N - Who? _____

Emergency Contact:_____

Relationship: _____ Phone: _____

Address: _____

If under 18, name of parent: _____ Phone: _____

WE UNDERSTAND THIS FORM IS LENGTHY AND TEDIOUS. HOWEVER, PLEASE UNDERSTAND, SUCCESSFUL HEALTH CARE IS ONLY POSSIBLE WHEN THE PRACTITIONER HAS A COMPLETE UNDERSTANDING OF THE CLIENT, BOTH PHYSICALLY AND EMOTIONALLY. THEREFORE, WE ASK THAT YOU PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. THE MORE WE KNOW THE MORE WE CAN HELP. **PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK**.

Are you currently receiving healthcare? **Y** **N**

If yes, where and from whom? _____

What was the reason? _____

If no, when and where did you last receive medical or health care? _____

_____

List, in order of importance, your health concerns that are most important to you.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Current State of Health

Allergies: Do you currently know if you are hypersensitive or allergic to...?

Any drugs? _____

Any foods? _____

Any environmental? _____

Current Medications

Prescription Medications

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Over the counter medications

1) _____ 3) _____

2) _____ 4) _____

Supplements and Vitamins

1) _____ 6) _____

2) _____ 7) _____

3) _____ 8) _____

4) _____ 9) _____

5) _____ 10) _____

Habits	Yes	No	In past	Additional Information
Do you exercise? If yes please fill in below				
How many hours of sleep do you get per night? **( )**				
Do you sleep well?				
Do you wake rested?				
Fall asleep easily?				
Wake in the night?				
Do you enjoy your work?				
Do you have a supportive relationship?				
Do you have a history of being abused?				
Do you use recreational drugs?				
Have you been treated for drug dependence?				
Have you been treated for alcoholism?				
Do you use tobacco products?				
How many packs per day? **( )**				
How many years? **( )**				

Exercise

Days per week: _____, Length of workouts: _____, Types of Activities: _____ _____ _____

Meals per day:_____, Snacks:_____, Caffeinated Drinks:_____, Alcohol/week: _____

Interests/Hobbies: _____

Hospitalizations and Surgeries

_____ Year: _____ _____ year: _____

_____ Year: _____ _____ year: _____

_____ Year: _____ _____ year: _____

Traumas (including accidents, situations of abuse, etc.)

_____ Year: _____ Result: _____

_____ Year: _____ Result: _____

_____ Year: _____ Result: _____

_____ Year: _____ Result: _____

Family History	Father	Mother	Brothers			Sisters			Spouse	Children		
Age if still living												
Health P=Poor, G=Good												
Age at Passing												
Check (✓) all that apply												
Cancer												
Heart Disease												
Diabetes												
High Blood Pressure												
Stroke												
Mental Illness												
Dementia												
Autoimmune Disease												
Asthma / Hay Fever												
Other												
Cause of Death if other												

Please check any conditions or symptoms you currently have now with a (C) and any you have had in the past with a (P).

Diagnostic History

____ Heart Disease
____ Stroke
____ Cancer
____ Autoimmune Disease
____ Thyroid Disease
____ Arthritis
____ Gastritis/Pancreatitis
____ Liver Disease
____ Gallbladder Disease
____ Kidney Disease
____ Food Allergies
____ Diabetes
____ Chronic Fatigue
____ Anemia
____ Infertility / Impotence
____ Hypo/Hyperglycemia
____ Hepatitis _____
____ Raynaud's Disease
____ Respiratory Allergies
____ Lyme's Disease
____ Chronic Pain Condition
____ Emphysema
____ Alcoholism
____ Drug Abuse
____ Depression/Anxiety
____ Psychotic Disorder Other:
_____

General

____ Poor Appetite
____ Poor Sleeping
____ Fatigue
____ Fevers
____ Chills
____ Night Sweats
____ Sweats Easily
____ Tremors
____ Cravings
____ Localized Weakness
____ Poor Balance
____ Change in appetite
____ Bleed/Bruise easily
____ Weight loss
____ Weight Gain
____ Peculiar tastes/smells
____ Dental/gum problems
____ Muscle weakness/fatigue
____ Sudden energy drops
____ Strong thirst

Head, Eyes, Ears, Nose and Throat

____ Headaches
____ Dizziness
____ Difficulty swallowing
____ Migraines
____ Glasses
____ Eye Strain/Pain
____ Poor/ Blurred vision
____ Spots in front of eyes
____ Night Blindness
____ Color Blindness
____ Cataracts
____ Earaches
____ Ringing in ears
____ Poor hearing
____ Sinus problems
____ Nose bleeds
____ Sore throats/colds
____ Grinding Teeth
____ Facial pain
____ Sores on lips/tongue
____ Dental problems
____ Jaw clicks/lock

Skin and Hair

____ Rashes ____ Eczema/Psoriasis ____ Skin discoloration ____ Warts
____ Ulcerations ____ Dandruff ____ Acne ____ Dermatitis
____ Itching ____ Loss of hair ____ Face flushing ____ Fungal Infection
____ Hives ____ Recent moles ____ Change in skin/hair texture ____ Weak or ridged nails

Cardiovascular

____Low blood pressure ____Blood Clots ____Fainting ____Spontaneous sweating
____High blood pressure ____Phlebitis ____Cold hands/feet ____Elevated Cholesterol
____Irregular heart beat ____Shortness of breath ____Swelling of hands/feet Other: _____
____Palpitations at rest ____Chest pain or pressure ____Varicose/spider veins

Respiratory

____Asthma ____Emphysema ____Cough/Wheezing ____Difficult inhale/exhale
____Bronchitis ____COPD ____Coughing Blood ____Production of phlegm
____Pneumonia ____Pain on inhalation ____Tight sensation in chest What color? _____

Gastrointestinal

____IBS ____Belching ____Vomiting ____Poor appetite
____Crohn's Disease ____Bloating/Distension ____Hemorrhoids ____Excessive appetite
____Colitis ____Abdominal pain/cramps ____Rectal pain ____Significant thirst
____Acid reflux/GERD ____Constipation ____Black stools ____Hernia
____Indigestion ____Chronic laxative use ____Blood in stool
____Nausea ____Diarrhea ____Bad breath Other: _____
____Gas ____Loose stools ____Changes in appetite

Genito-Urinary

____Pain on urination ____Copious flow ____Premature ejaculation ____Pain in testicles
____Frequent urination ____Kidney Stones ____Nocturnal emission ____Herpes
____Blood in Urine ____Impotence ____Decreased Libido ____STD Infections
____Urgent urination ____Sores on Genitals ____Excessive libido
____Unable to hold urine ____Urinary Tract Infection ____Prostatitis
____Scanty Flow ____Burning urination ____Dribbling after urination

____Night urination… What time? _____ How often? _____ _____

Gynecological/Reproductive

____Ovarian cysts ____PMS ____ Painful intercourse ____Vaginal discharge
____Endometriosis ____Menopause ____Vaginal dryness ____Infertility
____Uterine Fibroids ____Fibrocystic breast tissue ____Vaginal sores ____Use Birth Control
____Irregular Menstrual Cycles

_____Date of last menses _____Date of last PAP/Pelvic

Musculoskeletal

____Neck pain ____Hand/wrist pain ____Knee pain ____Muscle weakness_____
____Shoulder pain ____Carpal Tunnel ____Foot/ankle pain ____Tendonitis_____
____Rotator Cuff ____Hip pain ____Sprains/Strains ____Bursitis_____
____Elbow Pain ____Sciatica ____Muscle pain_____
____Back pain Low___ Middle___ Upper___

Neuropsychological

____Anxiety/Panic attacks ____S.A.D ____Vertigo/Dizziness ____ADD/ADHD
____Nervousness ____Bad temper/irritable ____Loss of balance ____Dyslexia
____Easily Over Stressed ____Bi Polar ____Poor Coordination ____Poor memory
____Depression ____Seizures ____Concussion_____

Areas of numbness: _____

Have you ever; been treated for emotional problems? _____, or considered / attempted suicide? _____

How much change and effort are you willing to make to improve your health? ☐ MINIMAL ☐ SOME ☐ COMPLETE

_____ _____
Signature Date

_____ _____
Signature of Parent or Guardian Date

I N T E G R A T I V E A N D C O M P L E M E N T R Y

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As a client of Robert Guiel's M.S., I clearly understand that I am not being treated for any specific disease. I understand that the treatment received at this office is for the purpose of rebalancing both the structure and bio-electric reflexes of the body.

The nutritional supplements received at this office or recommended from this office are **not** drugs or medicines. They are vitamins, amino acids, mineral food complexes, herbal formulations and homeopathy.

The Reflex Analysis used at this office is only used to find increased bio-electric points, which may indicate a deficiency. This work is not and cannot be used to render a physical diagnosis, nor is this work linked to any type of diagnosis.

As with all health care treatment, a guarantee cannot be given that such treatment will result in a restoration of health.

I have read the above paragraphs and understand them fully

_____ _____

Signature Date

_____

Print Name