Kathryn Hark Client Questionnaire

Please Print
Last Name _____First Name_____
Street _____City _____ Zip _____
Home Phone_____Work Phone _____
Gender: M_____ F_____ Age_____ Birthdate_____
E-mail_____ Date:_____

I. Musculo-Skeletal

Please mark any of the following that you currently have or have had in the past:

Past	Present	
☐	☐	Aches or pains Location_____ Meds prescribed for_____
☐	☐	Accidents or injuries _____
☐	☐	Surgeries _____
☐	☐	One leg shorter
☐	☐	Ligament laxity or chronic stiffness
☐	☐	Feet problems, ie. bunions, bowlegged _____
☐	☐	Scoliosis
☐	☐	Concussions
☐	☐	Overuse problems, ie. tennis elbow_____

How many hours a day are you at a desk? _____

Do you consume artificial sweeteners? ☐ Yes ☐ No
If yes, which ones? _____

Please list your chief complaint(s):

II. Respiratory

Please mark any of the following you currently have or have had in the past:

Past	Present		Past	Present	
☐	☐	Asthma	☐	☐	Hay fever / Pollen allergies
☐	☐	Bronchitis	☐	☐	Mouth breathing
☐	☐	Krups	☐	☐	Sinusitis

Do you have trouble breathing? ☐ Yes ☐ No
Do you have chronically stiff scalene (neck muscles)? ☐ Yes ☐ No
Can you hold your breath for a minute or more? ☐ Yes ☐ No

Comments:

III. Digestive System

Please mark any of the following you currently have or have had in the past:

Past	Present		Past	Present	
☐	☐	Heartburn	☐	☐	Diverticulitis
☐	☐	Gas/Bloating	☐	☐	Cramps
☐	☐	Loose stools	☐	☐	Infrequent elimination
☐	☐	GERD			

Have you ever had trouble digesting any of the following? ☐ Carbs ☐ Fats ☐ Meats

Beverages:

Do you drink diet sodas? ☐ Yes ☐ No

Do you use or consume artificial sweeteners (Splenda, Equal, Sweet n' Low, etc.)? ☐ Yes ☐ No

Do you drink reverse osmosis or distilled water? ☐ Yes ☐ No

Type(s) of water if no _____

Do you drink alcohol? ☐ Never ☐ Daily ☐ Weekly ☐ On rare occasions

Type(s) of alcohol _____

Supplements:

Please List _____

_____

Meals:

	Most Recent:	Typical:
Breakfast	_____	I_____
Lunch	_____	I_____
Dinner	_____	I_____

Antiobiotic Use:

More than 5 days? Yes ☐ No ☐ When? _____

What for? _____

Comments:

IV. Genito-Urinary

Do you have frequent urination? ☐ Yes ☐ No

Have you taken antibiotics for a genito-urinary condition? ☐ Yes ☐ No How many times?____

Do you have a history of kidney stones? ☐ Yes ☐ No

Please list oz. per day of: Water_____ Alcohol _____ Coffee/tea_____

What type(s) of water do you consume (ie. Mineral water, RO, filtered tap, bottled water, etc.)?

At home_____ At work_____

Comments:

Kidneys _____ Hydration _____

V. Circulatory

Please mark any of the following you have:

☐ Swelling / edema Where?_____
☐ Cold hands ☐ Cold feet Since when? _____
☐ Orthostatic hypotension (dizziness going from sitting to standing)
Any meds for this? _____
Do you have a history of high blood pressure or stroke? ☐ Yes ☐ No
Do either of your parents? ☐ Mother ☐ Father

Comments:

Subscap _____ Fingernails _____

VI. Immune

Do you have any known allergies? ☐ Yes ☐ No
If yes, please list _____
Do you have a spleen? ☐ Yes ☐ No
Do you struggle with runny nose or eyes? ☐ Yes ☐ No
What vaccines have you had? _____
_____
Do colds and flus generally go into your lungs? ☐ Yes ☐ No
How many colds and/or flus do you get a year? _____

Comments:

Lungs _____ Spleen _____

VII. Other Health Concerns

Please list and explain any other health concerns that were not listed above.

_____
_____
_____
_____
_____
_____

Comments: