HEALTH SURVEY

This is a health survey designed to help you assess where you are; recognition is well on the way to healing.

PLEASE BRING THIS FORM BACK WITH YOU EACH TIME.

I do not diagnose or treat any kind of condition of disease.

Please note: Always consult your doctor and *do not* go off any prescription drug without consulting him or her.

If you have any short questions between consultations, please feel free to call me at the store between 12:00 pm and 12:45 pm mountain time. Please realize that your phone call will be limited to five minutes or less.

Homeopathics, essential oils and flower essences are essentially non-toxic and can be used with prescription medications; they do not conflict with drugs.

Herbs can be foods, tonics, or strong medicines and may conflict with medications (over-the-counter or prescriptions). Always ask about complications. I generally recommend the non-conflicting food or tonic herbs.

Cancellations: 24-hour notice is required for cancelling appointments.

To make your next appointment, please visit https://daveshealth.com/appointment-with-dave/

Salt Lake Store	880 E. 3900 S. Salt Lake City
Phone: 801.268.3000	

FOR ALL HEALTH OR DISEASE CONDITIONS USE COMMON SENSE
AND CONSULT YOUR DOCTOR OR HEALTH CARE PROFESSIONAL.

Name: ____ Age: ________________

Birth date: __________________________ Time of day born: _________________ am pm
(You can lie about your age, but give the correct birthday)

Occupation: ____

Gender assigned at birth:

- ☐ **Male**
- ☐ **Female**

If female, check all that apply

- ☐ **Pre-puberty** (not menstruating)
- ☐ **Menstruating**

  If not, why? ____

  How many days between menstrual periods? ___________

  Menstrual period is:

  - ☐ Regular
  - ☐ Irregular
  - ☐ Heavy bleeding
  - ☐ Heavy cramping

- ☐ **PMS**
- ☐ **Miscarriage** – how long ago? ____
- ☐ **Infertility**
- ☐ **Chemical birth control** – what type? _____________________________________
- ☐ **Pregnant** – how far along are you? _______________________________________
- ☐ **Nursing –** how old is your baby? ____
- ☐ **MOM** – how many babies have you had? ____________________________________

  – how long ago did you have a baby? __________________________________

- ☐ **Menopause**

  - ☐ Hormone replacement – what type? _______________________________
  - ☐ Partial hysterectomy
  - ☐ Full hysterectomy
  - ☐ Dryness
  - ☐ Hot flashes - how often? ____

  Describe them along with the time of day they happen:

  ____

Note: Hormonal imbalances of all kinds include emotional symptoms such as irritability, mood swings, anxiety, memory problems, concentration, libido changes, crying, etc.

PRESCRIPTION MEDICATIONS

Drug name Year Started (how long used it?) Reason

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

10.____

11.____

12.____

13.____

14.____

15.____

Note: Antacids (acid blockers) stop stomach acid needed for proper digestion and are often a cause or contributor of anemia, mineral mal-absorption, and OSTEOPOROSIS. GERD or heartburn may be a sign of stomach irritation, not too much stomach acid. It just feels that way.

NON PRESCRIPTION MEDICATIONS (Over-the-counter)

Drug name Year Started (how long used it?) Reason

1.____

2.____

3.____

4.____

5.____

NATURAL SUPPLEMENTS (Herbs, etc)

Supplement name Reason

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

10.____

11.____

(Additional supplements may be written on the back of this page.)

My main concern(s) for coming today is:

Social circumstances:
I am…

- [ ] Single
- [ ] Partner, how long? _______________
- [ ] Married, how long? _______________
- [ ] Divorced, how long? ______________
- [ ] Widowed, how long? ______________

Conflicts with spouse or relatives? ____

____

If you have a partner, do you go out on regular dates?

- [ ] Yes
- [ ] No

If yes, how often?

- [ ] More than once a week
- [ ] Once a week
- [ ] Infrequent
- [ ] Almost never

Do you like your partner? ____

Sometimes people love their partners, but don't particularly like them. A wise man once determined how much you like someone by how much time, energy, and money you spend on them. Are you fooling yourself? Relationships can make or break your health.

Make a commitment with your partner to go out on regular dates.

Intimacy:
My *sex drive is:

- [ ] Low
- [ ] Medium
- [ ] High

Has there been a change in habits or desires over the last few weeks or months?

- [ ] Yes
- [ ] No
- [ ] Less interested in sex
- [ ] More interested in sex

Bowel habits:
How many bowel movements are you having daily? _______________ weekly? _____________

- ☐ Less often
- ☐ Using laxatives

Do you have…

- ☐ Hemorrhoids?
- ☐ Diarrhea?

Do you have other bowel challenges?

- ☐ IBS
- ☐ Crohn's
- ☐ Other (specify) ___________________
- ☐ Polyps

Emotional/Spiritual:
How much time do you spend each day to commune with your inner self or God? (These activities can include prayer, meditation, scripture study, etc.) This is a part of your physical health, just as surely as any other part.

- ☐ Every day
- ☐ Occasionally
- ☐ Once a week
- ☐ Almost Never

Sleep schedule:
In general, what time do you go to sleep? ________________ pm am

I general, what time do you wake up? ___________________ am pm

How many hours of sleep do you get per night? ____________

Quality of sleep is _______________________________ (Restful or restless?)

Check all that apply:

- ☐ I have trouble with waking during the night – what time? _______________
- ☐ I have trouble getting to sleep
- ☐ I have to urinate during the night – how many times? __________________

Exercise:
How often do you exercise?

- ☐ Daily
- ☐ Occasionally
- ☐ 2 – 4 times a week
- ☐ Not at all, sedentary
- ☐ 1 time a week

How long do you exercise each time? _______________________________________

Exercise, as well as deep breathing, massages your inner organs. **If you are not exercising, begin walking 20 minutes a day.**

Weight:

Any weight changes in the last couple of years? ____

____

How much change? ____

Weight goals____

____

Diseases: What are they and how are they being treated? (medications, etc.)

1.____

2.____

3.____

Injuries: What type of injury and when did it happen?

1.____

2.____

3.____

Surgeries: What type of surgery and when did you have it?

1.____

2.____

3.____

TRAUMA: Old traumas that changed your life…

I haven't been well since ____ happened to me.

I was a certain way and am now____

____

Dietary habits: Foods affect all aspects of health; physical, mental, emotional, and spiritual.

Building foods-Concentrate your diet with these foods to heal from serious diseases or for more energy. If raw foods give you gas, either steam them or cook them. Use these foods as your main staple. Check all the ones you usually eat.

- ☐ Organic foods
- ☐ Vegetables
- ☐ Raw foods
- ☐ Fresh, ripe fruits
- ☐ Green foods
- ☐ Raw seeds, raw nuts

Maintaining foods. Use them in moderation. Check all the ones you usually eat.

- ☐ Breads (use whole grains)
- ☐ Cooked foods (few or no enzymes)
- ☐ Spicy foods (may affect digestion)
- ☐ Meats (use sparingly)
- ☐ Legumes (can produce gas)
- ☐ Dairy (poorly absorbed, mucus forming, lactose problems)
- ☐ Some frozen foods (few or no enzymes)

Check the products that you consume on a regular basis.

- ☐ Tobacco
- ☐ Alcohol
- ☐ Fast foods
- ☐ Over the counter drugs
- ☐ Prescription drugs
- ☐ Recreational drugs
- ☐ Peanut butter
- ☐ Processed foods
- ☐ Stimulants
- ☐ Pork
- ☐ Sugar
- ☐ Soda pop
- ☐ Margarine
- ☐ Canned foods
- ☐ Coffee
- ☐ Fried foods

Food cravings____

____

Food sensitivities ____

____

Foods you avoid ____

OFFICE USE ONLY – LEAVE BLANK Date: ____________________________

GENERAL HEALTH STRATEGIES: