HAWAII NATUROPATHIC RETREAT
DETOXIFICATION · LIFESTYLE CHANGES · RAW FOOD · GERSON THERAPY
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APPLICATION FORM & QUESTIONNAIRE

GENERAL INFORMATION (Please print)

Today's date _____

Name _____

Age _____ **Sex (M,F)** _____

Place of birth _____ Birth date _____

Marital status _____ Number of children _____

Living situation (alone, family, friends) _____

Occupation _____

Address

_____

City _____ State/Zip/Country

_____

E-mail address _____
Fax_____

Phone (home) _____ **Phone** (work/cell)

_____

How did you hear about us? _____

OPTIONAL
(sometimes it can help explain your health problem)

Religion _____ Race _____

COMPREHENSIVE HEALTH HISTORY

YOUR CURRENT HEALTH PROBLEMS

What is your major health problem?

What are the symptoms? (Location, quantity, quality, or severity, timing, setting in which they occurred, factors that aggravate them or relieve them and associated manifestations.)

When did it start for the first time and setting in which it developed?

Describe any factors that you suspect may have played a role in its onset and continuation.

Is it becoming better or worse? Be specific in your description.

Describe past treatments for this problem.

Drugs: How long and what dosage taken?

Surgeries:

Natural treatments:

What treatment worked the best?

What treatment worked the least?

Do you have any other health problems? Please list in order of importance and describe.

Do you have any emotional issues that you would like to address?

Do you have any sexual issues that you would like to address?

Do you have any social issues that you would like to address?

Do you have any family issues that you would like to address?

Are you currently working with
a doctor of conventional medicine ___ yes ___ no
a naturopathic doctor ___ yes ___ no
a counselor, pastor, or other therapist ___ yes ___ no

Today's weight _____ Today's height _____

As an adult what has been your maximum _____ and minimum _____ weight?

Any recent weight change?

Do you feel weakness or fatigue? Explain.

Do you have an exercise routine? Describe.

Do you have any allergies and/or drug allergies?

YOUR HEALTH HISTORY:

Is your present state of health ___ excellent, ___good, ___average, ____fair, ___ poor.

General state of health: rate today's state compared to the past. (Rate from 1 to 10; 1 is the lowest, 10 is highest.)
Now _____ In the past _____ Please comment.

When during the day is your energy the best? _____ Worst? _____
Rate your energy level: Now _____ In the past _____

Childhood illnesses:
___measles ___rubella ___mumps ___whooping cough

___chicken pox ___rheumatic fever ____scarlet fever ___polio
Childhood immunizations and age at immunization:
___tetanus ___pertussis ___diphteria ___polio
___measles ___rubella ___mumps ___influenza
___hepatitus B ___hemophilus influenza ___pneumococcal vaccine

List adult illnesses, psychiatric illness, accidents, and injuries, operations,and hospitalizations by date of onset, starting with the oldest first:

Do you have any allergies to drugs, herbs, foods, animals, dust or other?

Have you been exposed to environmental hazards at home or on the job? (Please read "Where do you find heavy metal toxicity?" at the end of this questionnaire and mention situations where you may have been exposed to mercury, cadmium, or lead.)

Do you live in a new place or an old one? _____

How long have you lived there? _____

Is it damp and moldy, or dry? _____

Do you have new wall to wall carpeting? _____

Do you use aluminum cook pots? _____

Do you have an air filter at home? _____ At your job? _____

Do you live in a city, a suburban area, or in the country?
_____

Do you live near a golf course or any area that is heavily sprayed with pesticides?____

Do you work in the presence of toxic fumes or chemicals? _____

Do any of your hobbies involve toxic materials? _____

Are you presently exposed to secondhand smoke? _____ In the past? _____

If yes, for how long? _____

What is the source of your drinking water?_____

Do you have any silver-mercury fillings? _____ How many? _____

What are your leisurely activities? Describe type and frequency.

What is the quality of your sleep? How many hours of sleep do you get on average?

Current medications, amount and dosage:

Vitamins, herbal remedies, and supplements:

Do you smoke tobacco? ____ Have you smoked in the past? ____
How long? _____How much? _____

Do you drink alcohol? ___ Have you drunk in the past?____
How long? _____How much? _____

FAMILY HISTORY:
Age and health of parents, and if deceased, cause of death
Mother _____
Father _____
Brothers _____
Sisters _____
Mother's mother _____
Mother's father _____
Father's father _____
Father's mother _____

Family history of (indicate family member, severity, or death)

__diabetes __arthritis __mental illness __allergies
__tuberculosis __anemia __drug addiction __high BP
__heart attack __headache __alcoholism __hypoglycemia
__cancer __epilepsy __depression __stroke

Health of your children?

DIGESTION AND ELIMINATION:

Gastrointestinal

Do you have any problem with gas, bloating, or fullness after eating? __Yes __No

How Often? _____

How severe is the problem? (rate 1 to 10) _____

How long have you had this problem? _____

How often do you have a bowel movement? _____
Do you ever have blood, mucous, undigested food, or black stools? _____

Any rectal itching? _____

Do your stools tend to be formed or loose? _____

Do you have diarrhea, constipation, alternating diarrhea and constipation?

_____

Do you have thin, long, narrow stools? _____ How often? _____

Do you have small, hard stools? _____ How often? _____

How often do your stools have a strong disagreeable odor? _____

Have you ever fasted? _____ For how long? _____

Was it supervised, or did you fast by yourself? _____

Have you traveled outside the USA in the last 5 years? _____

Have you gone camping in the last 5 years? _____

Kidneys and Bladder

Have you had recurrent bladder infections? _____

How were they treated? _____

Do you have any burning sensation during or after urination? ____

Is your urine dark yellow, bright yellow, pale yellow, cloudy, or clear? (circle)
Does your urine have a strong odor to it? _____

Do you perspire when you exercise? ____ Lightly, moderately, heavily. (circle)

Does your perspiration have a strong odor to it?_____

MEDICAL SYMPTOMS RATING SCALE:

Rate each of the following symptoms according to the following scale:
0 never or almost never have this symptom
1 occasionally have it, effect is not severe
2 occasionally have it, effect is severe
3 frequently have it, effect is not severe
4 frequently have it, effect is severe

HEAD
___ headaches
___ faintness
___ dizziness
___ insomnia Total ____

EYES
___ watery or itchy
___ swollen, reddened, or sticky eyelids
___ bags or dark circles under eyes
___ blurred or tunnel vision Total ____

EARS
___ itchy ears
___ earaches or ear infections
___drainage from the ears
___ringing or hearing loss Total ____

NOSE
___ stuffy nose
___ sinus problems
___ hay fever
___ sneezing attacks
___ excessive mucus formation Total ____

MOUTH AND THROAT
___ chronic coughing
___ gagging, frequent need to clear throat
___ sore throat, hoarseness, loss of voice
___ swollen or discolored tongue, gums, or lips
___ canker sores Total ____

SKIN
___ acne
___ hives, rashes, dry skin
___ hair loss
___ flushing, hot flashes
___ excessive sweating Total ____

HEART
___ irregular or skipped heart beat
___ rapid or pounding heart beat
___ chest pain Total ____

LUNGS
___ asthma and/or bronchitis
___ chest congestion
___ shortness of breath
___ difficulty breathing Total ____

DIGESTIVE TRACT
___ nausea and/or vomiting
___ diarrhea
___ constipation
___ bloated feeling
___ belching, passing gas
___ heartburn
___ intestinal and/or stomach pain Total ____

JOINTS AND MUSCLES
___ pain or aches in joints
___ arthritis
___ stiffness or limitation of movement
___ pain or aches in muscles

___ feelings of weakness or tiredness Total ____

ENERGY AND ACTIVITY
___ feelings of fatigue or sluggishness
___ feelings of apathy or lethargy
___ hyperactivity
___ restlessness Total ____

MIND
___ poor memory
___ confusion, poor comprehension
___ poor concentration
___ poor physical condition
___ difficulty making decisions
___ stuttering or stammering
___ slurred speech
___ learning disabilities Total ____

EMOTIONS
___ mood swings
___ anxiety, fear, nervousness
___ anger, irritability, aggressiveness
___ depression Total ____

OTHER
___ frequent illness
___ frequent or urgent urination
___ genital itch or discharge Total ____

GRAND TOTAL ____