SALUTOGENESIS QUESTIONAIRE
(Please fill out the following to the best of your ability)

What is the main reason why you are seeking integrative medical care? (please answer in the space provided)

Personal Information

Name: _____

Address: _____

Phone: _____

Age: _____ Sex: _____

Date of birth: _____

Place of birth: _____

Birth order: _____

Relationship (please check):

Single ☐ Married/Relationship ☐ Divorced/Widowed ☐

Do you have children: Yes ☐ No ☐

If you answered 'yes' above, please list your children's ages:

_____

Please list your hobbies:

_____

Do you, or have you ever, smoked Cigarettes? Yes ☐ No ☐

If yes, how much and how long?

_____

Have you used any other recreational drugs? If so, what, and how much/long (please answer in the space provided):

Do you, or have you, consumed alcohol? Yes ☐ No ☐

If you answered yes to the above:

How frequently do/did you consume alcohol?

_____

How much alcohol do/did you normally drink in one setting?

_____

Allergies
Please list any allergies you have or have had:

Medication

Please list prescription medications you are currently taking:

Supplements (Please list everything):

Physical activity
Please describe your daily activities and any physical exercise you do, and how often:

Mental and/or Physical Stress
Please list and describe any mental or physical stresses you are experiencing:

Are you sexually active? Yes ☐ No ☐

If you answered yes, how satisfied are you with your sexual life?

Spirituality/Faith
Please describe what brings meaning to your life:

Family Medical History

Please list any illnesses for the following:

Mother :

Father:

Siblings:

Occupation

What is your occupation? _____

Please list any environmental exposure to toxins you have experienced as a result of your occupation:

_____

Medical Problems

(please check all that apply)

- ☐ Insomnia and sleep problems
- ☐ Diabetes Mellitus
- ☐ Thyroid problem
- ☐ Hypertension
- ☐ Heart disease
- ☐ Stroke
- ☐ Dementia
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ High cholesterol
- ☐ Recurrent infections
- ☐ Overweight
- ☐ Arthritis
- ☐ Autoimmune disorders
- ☐ Fibromyalgia
- ☐ Fatigue
- ☐ Irritable bowel

☐ Cancer
☐ Other

If you checked “recurrent infections,” what kind?

_____

If you checked “cancer,” what kind?

_____

If you checked “other,” please list:

_____

Past Surgeries

Please list any surgeries or operations you have undergone and when:

Trauma and injury

Please list any trauma or injury you have experienced (breaking a bone is not necessary).

Adverse Childhood Experiences

Please check all that apply:

- ☐ Parental divorce or seperation?
- ☐ Physical, mental or sexual abuse?
- ☐ Felt alone, unloved and uncared for?
- ☐ Lived with someone with mental illness or depression?

Diet

3 day review (please list meals):

	Day 1	Day 2	Day 3
Breakfast	_____	_____	_____
Lunch	_____	_____	_____
Dinner	_____	_____	_____
Snacks	_____	_____	_____

Do you use sweeteners? Yes ☐ No ☐

Physical/Mental Constitution

Weight (please check):

- ☐ Low, may forget to eat. Tendency to loose weight
- ☐ Moderate, Easy to gain or loose
- ☐ Heavy, gain weight easily and have difficulty losing it

How do you feel about your weight currently?

_____

Skin (please check):

- ☐ Dry rough thin
- ☐ Warm, red, prone to irritation
- ☐ Thick, moist, smooth

How do you feel about your skin currently?

_____

Hair (please check):

- ☐ Dry, brittle frizzy
- ☐ Thin with greying
- ☐ Thick and oily

How do you feel about your hair currently?

_____

Joints (please check):

- ☐ Thin prominent and tendency to crack
- ☐ Loose and flexible
- ☐ Large and padded

How do you feel about your joints currently?

_____

Temperament (please check):

- ☐ Lively, enthusiastic, like change
- ☐ Purposeful, intense. Like to convince others
- ☐ Easygoing, accepting. Like to support others

Under stress I become (please check):

- ☐ Anxious or worried
- ☐ Irritable or aggressive
- ☐ Withdrawn or reclusive

Thank you for your diligence in filling out the questionnaire.