Truly Heal Questionnaire

Questionnaire

CONTACT INFORMATION

FIRST NAME

LAST NAME

STREET ADDRESS

STREET ADDRESS LINE 2

CITY

ZIP CODE

State

PHONE NUMBER

Country

EMAIL ADDRESS

DOB: DD/MM/YYYY

Relationship Status

- Married
- Single
- Divorced
- Widow/Widower

How many children do you have?

Weight (please indicate units)

Hight (please indicate units)

What are your main concerns?

If you have cancer, when were you diagnosed? What is the diagnose?

What kind of medical intervention did you have since your diagnose? Please elaborate!

Occupation history

General / Past Medical History

Please try to describe as accurate as possible.

Did you have a natural birth?

- Home Birth
- Natural Birth (hospital)
- Medicated Birth
- Cesarean Section
- Water Birth

Did you have jaundice as a baby?

- YES
- NO
- Don't know

Were you breastfed and for how long?

Did you have childhood vaccinations?

What kind of childhood diseases did you have? (list in chronological order)

How would you consider your childhood?

Often sick and lacking energy

Somewhere in between

Robust and full of energy

How many rounds of antibiotics did you have in your lifetime? (please list why you had them)

Have you had any major accidents? If YES what kind.

Have you had any surgeries? If yes please state with year and what they concerned:

Have you had any major disease after you turned 18? Please state them chronological.

Have you had any major traumas? Please state them chronological and what they concerned.

From which of these diseases are you still suffering (if applicable)?

Have you ever used steroid, cortisone or similar medication for more than 2-4 weeks?

Please write down the medical conditions your first degree relatives have.

Supplementation and Drugs

Please try to describe as accurate as possible.

Please list all Supplements and Herbs you are currently taking? Name/Brand/Dose/Frequency/ For how long?

Please list all prescription and over the counter medications / drugs you are currently taking?
Name/Brand/Dose/ Frequency/For how long?

Oral Health

Describe your oral condition

- I have amalgam fillings (describe below how many)
- I had amalgam fillings (describe below how many)
- I have any root canal fillings (describe below how many)
- I have foreign/prosthetic objects
- I have different metals in my mouth (describe below how many)
- I have ulcers
- I have decay
- I have gum bleeding
- I have periodontitis
- I have dead / dark teeth
- NONE OF THE ABOVE

Please try to describe as accurate as possible. Oral health is a very critical subject and would be the most important part of scrutiny in a holistic clinic. Chinese medicine can determine almost all diseases from your mouth.

Describe your oral condition in your own words.

If you had Amalgam Fillings, how were they removed? (biological dentist / detox/ iv's/ ...)

Digestive Health

Please be honest and as accurate as possible.

Do you suffer from:

- abdominal bloating
- intestinal gas / farting
- burping
- indigestion
- heartburn
- cramps and pain
- NONE OF THE ABOVE

Have you had any surgery in your stomach area? If so what was done?

Do you suffer regularly from diarrhea, constipation or suffer from IBS? (irritable bowl syndrome)

Do you suffer from nausea relating to food?

Do you have or suspect that you suffer any food intolerances or allergy symptoms? Please state all symptoms you have:

How is you stool? Please describe;

- it floats
- it sinks
- stinks (bad odor)
- soft
- watery
- hard
- contains undigested food particles
- has a shiny look with fat droplets floating in water
- has blood and is black
- has mucus
- Well formed and regularly
- NONE OF THE ABOVE

How often do you have bowel movement per day?

Do you rely on any of the following for bowel elimination?

- Enemas
- Laxatives
- Exercise / Massage
- NO NOTHING

What type/brand of Laxatives

If you are carrying excess fat, where is it located?

- Hips , thighs and leg area
- Abdominal (belly area)
- Everywhere
- No

Urinary Health

Please try to describe as accurate as possible.

Do you suffer from bladder infections? If so how many per year/month (however applicable).

How often do you urinate per day?

Is there any discomforted or pain associated with urination?

Do you experience fluid retention?

Do you ever experience any lower back pain? If so please indicate where on your back.
(lower / upper / neck)

Have you ever suffered from kidney stones?

Do you struggle starting and stopping your urine?

Do you suffer incontinence?

Please describe your normal urine; colour, cloudy, blood and odor?

Respiratory System

Please try to describe as accurate as possible.

Have you ever suffered from respiratory disease? E.g. bronchitis, sinusitis.

Do you smoke or have been smoking in the past? How long?

Immune System

Please try to describe as accurate as possible.

Have your tonsils or adenoids been removed?

Have you had your appendix removed?

Do you have regular colds and flu's and even fever?

Can you remember when you last had a fever?

Cardiovascular System

Please try to describe as accurate as possible.

Do you know your blood pressure? (please indicate value)

Do you suffer from any dizzyness, Lightheadedness, or ear problems?

Do you have pain in your calves when walking?

Do you have problems with varicose veins?

Do you bruise easily?

Do you have tingling and numbness in hands and feet?

Do you have cold hands or feet?

Do you suffer from hemorrhoids?

Do you suffer from fluid retention in ankles and feet?

Questions to evaluate your eating habits:

Please fill out the below diet diary. It is designed as an insight into your 'average' daily diet. Please describe your food as honestly and extensively as possible. E.g. Veggies (what kind of veggies? How are they prepared? How big is the serving? Do you eat meat with it? How is it prepared?)
If you have changed your diet recently then please also describe what you have been eaten beforehand.

Are you responsible for your own food choices/preparation?

Breakfast

Morning Tea

Lunch

Afternoon Tea

Dinner

Do you have an aversion to any foods?

Do you crave salty foods?

Do you crave sweet foods?

Do you have any allergies to food?

Do you have any food sensitivities?

Do you eat processed meats? (sausages, bacon..) (how often)

Do you eat margarine?

Do you eat white bread? (how often)

Do you eat pasta and rice? (how often)

Do you eat packaged breakfast cereals? (how often)

Do you eat deep fried foods? (how often)

Do you eat soy products? (how often)

Do you eat GLUTEN ?

Do you eat DAIRY ?

Do you have problems with digesting fat?

How do you mostly feel after you have been eaten? (tired or energized)

How is your appetite throughout the day?

Do you follow any special diet and if so why?

If you are a vegan/vegetarian are you prepared to eat meat or fish if advised to?

Do you eat snacks or sweets not covered in your diet diary?

Do you eat out and if so what do you normally eat?

Do you think you have the perfect diet?

How many times a week do you consume fish and if so what kind?

Do you consume meat, if so how many times a week and what kind?

Questions to evaluate your drinking habits:

How many liters of ‘water’ do you drink a day?

How many liters of liquid other than water do you drink a day?

Do you drink coffee and if so how many cups and when?

Do you drink alcohol and if so how often per week/month (however applicable)?

When you do you drink alcohol how much do you consume?

Do you drink fruit juice and if so how much?

Do you consume liquid with your meals?

Do you get thirsty?

Do you drink alkaline water?

Do you have a water filter?

Toxic Exposure Assessment

If you are uncertain please talk with your parents / partner/ children to get accurate observations.

Do you have any hobbies or a job which exposes you to chemicals and pesticides such as working in a lab, farming, home garden, carpentry, hairdressing, painting, dentistry ? Please list all!

Have you been a frequent flyer?

Have you had many X Rays, CT scans?

Do you live in a house, flat or other accommodation that was built before 1970?

Have you lived in a building with mould or persistent unrepaired water leaks?

Is your furniture made out of particle board?

Do you dry clean your clothes?

Do you have a sofa or mattress made out of polyurethane foam?

Do you use fragrances?

Do you use conventional care products and cosmetics?

Do you drink water from plastic bottles?

Have you eaten much fish before or since you've been ill, especially tuna, swordfish, shark, or other large fish near the top of the food chain?

Allergy Assessment

If you are uncertain please talk with your parents / partner/ children to get accurate observations.

Did you have eczema as a child?

Do you suffer from any skin problems (eczema, psoriasis, itchy skin, hives)?

Do you experience sneezing, persistent runny or itchy nose?

Do your eyes itch, water, get red or swell?

Do you have asthma, wheezing or chronic cough?

Do your symptoms worsen during a particular season?

Do your symptoms change when you go inside or outside?

Are your symptoms worse in your bedroom after going to bed?

Are your symptoms worse in dusty areas?

Do you have mood swings or feel depressed for no reason?

Do you have any relatives with allergies?

Do you sometimes feel stimulated or fatigued after meals?

Do you have dark circles under your eyes?

Endocrine System

Please try to describe as accurate as possible.

Do you suffer from hair loss?

Do you have cold hands and feet and are you sensitive to cold?

Do you experience fatigue during the day? please elaborate

Do you have dry skin?

Do you have difficulty losing weight?

Do you gain weight easily?

Do you have low libido?

Do you have regular sex?

Are you tired when you awaken?

Do you have afternoon fatigue?

Do you have thinning of your eyebrows or eyelashes?

Is your voice hoarse?

Estrogen Dominance

Please try to describe as accurate as possible.

Please tick if applicable:

- anxiety, irritability, anger or agitation
- cramps, heavy bleeding, prolonged bleeding and clots
- water retention/weight gain, bloating throughout your cycle
- breast, tenderness, lumpiness, enlargement or fibrocystic breasts
- mood swings, depression, and weepiness
- headaches/migraines
- muscle pains, joint pains, back pain
- acne
- foggy thinking, memory difficulties
- fat gain, especially in the abdomen, hips and thighs
- cold hands and feet? Adrenal relation
- blood sugar levels vary and you suffer from insulin resistance
- have irregular periods
- have a decreased sex drive
- suffer from Gall bladder problems
- have infertility
- get insomnia
- have osteoporosis
- have endometriosis
- have Polycystic ovaries
- have uterine fibroids
- have cervical dysplasia? (Abnormal cells on PAP smear)
- have allergic tendencies
- suffer from any autoimmune disorders
- NONE OF THE ABOVE

Do you suffer from Pain?

Please try to describe as accurate as possible.

Please describe the area and the kind of pain you experience.

How do you deal with pain? (what do you do against it?)

FOR WOMEN ONLY! Menstrual Periods

Please complete this section to the best of your ability even if you no longer menstruate. It provides valuable information for an accurate assessment. If you are currently going through menopause please answer the following:

When did you stop menstruating?

Did you suffer from night sweats, hot flushes, moods and other vaginal issues?

Is there any other important information regarding your menopause that you think may be relevant?

Please answer the following questions regarding your cycle:

Average length of cycle?

Length of flow?

Regular cycles?

Light, Heavy, Clots and Color of blood?

PMS? (Please describe symptoms)

Do you have or had uterine fibroids?

Do you have or had fibrocystic breast disease?

Do you have or had endometriosis?

Have you had infertility problems?

Have you had a miscarriage and if yes when?

Do you have anxiety or panic attacks?

Are you currently using or ever used birth control pills? For how long?

Are you currently on or have ever used a long lasting contraceptive (implanon, IUD, depot injection,

Do you or have you ever used Hormone replacement therapy (HRT)? If so please elaborate.

Do you have any sexually transmitted diseases?

Do/did you suffer from thrush?

Questions to evaluate your exercise habits:

Please try to describe as accurate as possible.

How often a week do you exercise?

What kind of exercise do you perform?

How do you feel after exercise?

Where do you exercise?

Do you get cramps or sore muscles after exercise?

Questions to evaluate your sleeping habits:

Please try to describe as accurate as possible.

When do you go to sleep?

When do you wake up?

How many hours of sleep do you get per night?

How many hours of sleep do you feel like you need a night?

How long did it take you to fall asleep?

Do you wake during the night? How often?

Was there a reason you woke up (baby, bathroom, other noise disturbances)?

Did you have trouble falling back asleep?

When you wake up in the morning do you feel refreshed?

After waking how long does it take you to get hungry?

How are your energy levels during the day?

Rate your energy level out of 1-10 (1 being really tired and 10 being full of energy)?

Is there a better or worse time during the day?

Do you have any naps during the day?

Psychological

Please try to describe as accurate as possible.

How would you classify your stress level 1-10 before being diagnosed? (from 10 being the highest)

How is your stress tolerance?

Do you suffer from:

- migraines
- headaches
- poor memory
- concentration problems
- foggy head
- NONE OF THE ABOVE

Do you suffer from anxiety or panic attacks?

Do you feel often angry/irritable?

Do you suffer from insomnia or other sleep disorders?

Questions to evaluate your spiritual STRESS:

Do you have stress, anger and resentment with siblings? If yes, please describe:

Do you know your life purpose or have a strong passion that motivates you?

Do you have any regular spiritual praxis? (meditation, prayer, yoga)

Do you have stress, anger and resentment with parents/children? If yes, please describe:

How do you rate your parents care for you?

Abuse

Neglect

Caring

Smothering

Domineering

Do you have stress, anger and resentment with siblings? If yes, please describe:

Do you have stress, anger and resentment with spouse or partner? If yes, please describe:

Do you have stress, anger and resentment with work colleagues? If yes, please describe:

Questions to evaluate your mental STRESS:

If people are rude to me I just shrug it off?

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I am confident in what I do

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I strive to do the best I can

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I feel uneasy if I'm in the centre of attention

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I like to react to things on the spur of the moment

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I don't like unexpected responsibilities

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I approach life in an easy-going manner

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I tend to take on other people's problems

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I like to have plenty of time for myself

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

During tough times, I am more prone to unhealthy behaviors (abusing drugs or alcohol, eating unhealthy foods, getting less sleep).

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

When I meet someone new, it doesn't take me long to tell him/her a lot about myself.

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I am good at thinking "outside the box".

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I find it difficult to function normally when I'm under pressure to meet a deadline.

Strongly disagree
disagree
neutral
agree
strongly agree

Do you do regular meditation or other concentration exercises?

Do you have a hard time to stop repeating thoughts?

Are you able to calm yourself with breathing exercises?

Do you have signs like stiff neck, twitching eye or other nerve signals that you are stressed?

Questions to evaluate your financial STRESS:

Do you worry a lot about money and being able to pay the bills?

Do you have a positive outlook on earnings and a confident attitude that you manage the future?

Has money been a hot subject with loads of ups and downs?

Do you rather save money and invest it, or do you rather spend it when you have it at hand?

Questions to evaluate your Social STRESS:

Everybody has to fend for themselves; I cannot look out for others.

Strongly disagree
disagree
neutral
agree
strongly agree

I feel like I'm on an emotional roller coaster.

Strongly disagree
disagree
neutral
agree
strongly agree

I feel like a failure compared to my family, friends and co-workers

Strongly disagree
disagree
neutral
agree
strongly agree

I am happy to make speeches in public

Strongly disagree
disagree
neutral
agree
strongly agree

I would describe myself as an extremely competent person

Strongly disagree
disagree
neutral
agree
strongly agree

Do people say: “thank you, well done, great achievement” ?

Do people admire you and follow your lead?

Do you think you do not get adequate recognition and appreciation?

Questions to evaluate your Career STRESS:

I can work even when things are disorganised

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I consistently put full time and effort into everything I do

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

I am able to complete tasks as well as, or better than other people

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

It is very important for me to achieve my goals

- Strongly disagree
- disagree
- neutral
- agree
- strongly agree

Do you need to perform work that you: do not like? / hate? / make you sick?

Do you have stress with work colleagues?

Do you have to work under pressure and in a critical sitution?

Is your work uninspiring and boring?

What do you do for work?

Do you have any hobbies and yes what kind?

Please upload your latest test results (blood, stool, hair, saliva, scans) or any medical evaluation.

Attach in Email or upload.