Sara Kendall Gordon, L. Ac. DAOM
Marin Optimal Health

Health Questionnaire

Circle the "YES" the answers only

Notes

1. Do you have a tendency to faint? Yes No
2. Do you bruise or discolor easily? Yes No
3. Do you bleed easily? Yes No
4. Have you ever had hepatitis? Yes No
5. Have you had an AIDS test? Yes No
6. Are you HIV+? Yes No
7. Do you have high blood pressure? Yes No
8. Do you have heart problems? Yes No
9. Do you have respiratory problems? Yes No
10. Do you have digestive problems? Yes No
11. Do you have bowel trouble? Yes No
12. Do you have prostate pain? Yes No
13. Do you have kidney/bladder trouble? Yes No
14. Do you sweat a lot? Yes No
15. Do you have headaches? Yes No
16. Do you have PMS? Yes No
17. Do you have excessive thirst? Yes No
18. Are you in acute pain? Yes No
19. Do you have chronic pain? Yes No
20. Are you taking any therapies at this time? Yes No
21. Are you taking any medication/drugs/herbs Yes No
    (if so, list on the right)
22. Have you had any surgeries or operations? Yes No
    (if so, list on the right)
23. Are you hungry at the present time? Yes No
24. Are you exhausted at the present time? Yes No
25. Are you nervous at the present time? Yes No
26. Are you allergic to anything? Yes No
    (if so, list on the right)
27. Do you exercise regularly? Yes No
    How much?_____
28. Do you drink alcohol? Yes No
    (frequency)_____
29. Do you smoke cigarettes? Yes No
    (frequency)_____
30. Do you use street drugs? Yes No
    (frequency)_____
31. (Females) Are you pregnant at this time? Yes No
    Last monthly period?_____

Which areas of healing interest you?

- Acupuncture ☐
- Nutritional Herbal Supplements ☐
- Meditation ☐
- Energy Healing ☐
- Hypnotherapy ☐
- Massage ☐
- Living Well Groups ☐
- Living Well Intensives ☐
- Living Well Retreats ☐
- Other (specify) ☐