Rawlife Wellness

Health History Questionnaire

Please print clearly! Use a dark colored ink to ensure readability.

Personal Information

Date Completed:

Name:_____ Gender: ☐ M ☐ F Age: _____

Height: _____ (ft.) Weight: _____(lbs.) OR _____ (kgs.) Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Country: _____ Province: _____ Int'l Dialing Code: _____

Phone: _____ Cell Phone: _____ Alt. Phone: _____

Skype: _____ I have worked with Dr. Morse's formulas before: ☐ YES ☐ NO

Family Physician:
☐ Yes. The information is listed below. ☐ No. I do not have a family physician.
Physician Information:

Vitals Information

If you are not sure of your vital sign readings you may leave them blank.

Eye Color: Brown Blood Pressure – Left: _____ Blood Pressure – Right: _____

Pulse: _____ Respirations: _____ Basal Temp.(F): _____ pH (urine or saliva): _____

How many bowel movements do you have per day? How often do you move your bowels per week?

What does your current diet consist of? Be honest!

The Counselor may recommend glandulars to "power punch" certain glands. Please let us know as to whether or not you would like glandulars considered. Select one: ☐ YES ☐ NO

THYROID (GLANDULAR SYSTEM)

☐ YES ☐ NO	Do you get cold hands and/or feet?
☐ YES ☐ NO	Do you feel cold often or have a hard time getting warm?
☐ YES ☐ NO	Are you cold, but burning inside?
☐ YES ☐ NO	Is it easy to put on weight and hard to lose it?
☐ YES ☐ NO	Do you have an irregular heartbeat?
☐ YES ☐ NO	Do you get headaches or migraines?
☐ YES ☐ NO	Do you become irritable easily?
☐ YES ☐ NO	Do you have low energy levels?
☐ YES ☐ NO	Do you have, or have you ever had, a goiter?
☐ YES ☐ NO	Have you been diagnosed with ☐ **Hashimoto** or ☐ **Reidel** disease? Has a family member?
→	How much do you sweat? **Low** ☐ **Medium** ☐ **Excessive** ☐

PARATHYROID (GLANDULAR SYSTEM)

☐ YES ☐ NO	Are your fingernails **ridged** ☐ **brittle** ☐ or **weak** ☐ ?
☐ YES ☐ NO	Do you have varicose or spider veins?
☐ YES ☐ NO	Do you, or have you had, **hemorrhoids** ☐ or **prolapsed organs** ☐ ?
☐ YES ☐ NO	Do you experience cramping in your muscles?
→	Is your bladder strong or weak? **Strong** ☐ **Weak** ☐
☐ YES ☐ NO	Have you ever had a hernia?
☐ YES ☐ NO	Have you ever had an aneurysm?
☐ YES ☐ NO	Do you have osteoporosis and/or score low on your bone density tests?
☐ YES ☐ NO	Do you have scoliosis?
☐ YES ☐ NO	Do you suffer from symptoms of depression?
☐ YES ☐ NO	Do you suffer from any other mental illness? Which? _____

PARATHYROID (GLANDULAR SYSTEM) *Continued from page 2*

☐ YES ☐ NO Do your tests come back showing low Calcium levels?

☐ YES ☐ NO Do you have spine deterioration, herniated discs, or bone spurs?

☐ YES ☐ NO Do your legs get tired or cramp after you walk?

☐ YES ☐ NO Do you bruise easily?

PANCREAS

☐ YES ☐ NO Do you get gas after you eat?

☐ YES ☐ NO Do you feel your foods just sitting in your stomach?

☐ YES ☐ NO Do you have Acid Reflux?

☐ YES ☐ NO Do you see any undigested foods in your stools?

☐ YES ☐ NO Are you thin and have a hard time putting on weight?

☐ YES ☐ NO Do your foods pass right through you (diarrhea)?

☐ YES ☐ NO Do you have moles on your body? (Adrenal & Pancreatic weakness)

ADRENAL GLANDS (GLANDULAR SYSTEM)

☐ YES ☐ NO Are you overweight?

☐ YES ☐ NO Do you have **M.S.** ☐, **Parkinson's** ☐ or **Palsy** ☐?

☐ YES ☐ NO Do you have anxiety attacks or feel overly anxious?

☐ YES ☐ NO Do you feel excessive shyness or inferior to others?

☐ YES ☐ NO Do you have tremors, nervous legs, etc.?

☐ YES ☐ NO Do you have **High** ☐ or **Low** ☐ Blood Pressure?
→ **Systolic** _____ **Diastolic** _____

☐ YES ☐ NO Do you have hypogylcemia (low blood sugar)?

☐ YES ☐ NO Do you have Diabetes (high blood sugar)?
→ If yes: **TYPE I** ☐ or **TYPE II** ☐

☐ YES ☐ NO Do you have tinnitis (ringing in the ears)?

☐ YES ☐ NO Do you have S.O.B. (shortness of breath) or is it hard to take a deep breath?

ADRENAL GLANDS (GLANDULAR SYSTEM) *Continued from Page 3*

☐ YES ☐ NO Do you have heart arrhythmias?

☐ YES ☐ NO Do you have a hard time sleeping or insomnia? (pineal)

☐ YES ☐ NO Do you have Chronic Fatigue Syndrome?

☐ YES ☐ NO Have you ever been diagnosed with **Addison's Disease** ☐
or **Congenital Adrenal Hyperplasia** ☐?

☐ YES ☐ NO Do you have elevated blood cholesterol levels?

☐ YES ☐ NO Do you have arthritis, bursitis, or any inflammatory issues?

☐ YES ☐ NO Do you have any "itis's (inflammatory conditions)?
→ Which? _____
(arthritis, bursitis, rheumatoid arthritis, colitis, enteritis, phlebitis, neuritis, etc.)

☐ YES ☐ NO Do you have low steroid or cortisol levels?

☐ YES ☐ NO Have you been diagnosed with Autism?

☐ YES ☐ NO Have you been diagnosed with ADD (attention deficit disorder) or ADHD (attention deficit hyperactivity disorder)?

FEMALES ONLY

☐ YES ☐ NO Are your menstruation cycles irregular? (pituitary)

☐ YES ☐ NO Do you have excessive bleeding during menstruation?

☐ YES ☐ NO Do you have or have you had ovarian cysts? When? _____

☐ YES ☐ NO Do you have or have you had fibroids? When? _____

☐ YES ☐ NO Do you have or have you had endometriosis or A-typical cells?
→ Which ones? _____

☐ YES ☐ NO Do you have or have you had fibrocystic breasts? When? _____

☐ YES ☐ NO Do you get sore breasts, especially during menstruation?

☐ YES ☐ NO Do you have a low or excessive sex drive?

☐ YES ☐ NO Have you had a hysterectomy?
→ Date: Was it: **Partial** ☐ **Complete** ☐

FEMALES ONLY *Continued from page 4*

☐ YES ☐ NO Did they take any other organs out at the same time? (i.e.: galllbladder)
If yes, what other organs?
→ _____

☐ YES ☐ NO Have you had a D & C? If yes, date: _____

☐ YES ☐ NO Have you had a miscarriage? When? _____

☐ YES ☐ NO Have you had difficulty conceiving children in the **past** ☐ or **recently** ☐ ?

☐ YES ☐ NO Have you been on Birth Control Pills? For how long? : _____

☐ YES ☐ NO Are you currently pregnant?

MALES ONLY

☐ YES ☐ NO Do you have prostatitis (frequent urination esp. at night)?
→ If yes, how often do you urinate?: _____

☐ YES ☐ NO Do you have prostate cancer?
→ What are your PSA counts?: _____ date:

☐ YES ☐ NO Do you have testicular hypertrophy (enlargement)?

☐ YES ☐ NO Do you have a low or excessive sex drive?

☐ YES ☐ NO Do you have erection problems?

☐ YES ☐ NO Do you have premature ejaculation?
→ Other: _____

GASTRO-INTESTINAL TRACT

☐ YES ☐ NO Do you have gastritis or enteritis?

☐ YES ☐ NO Is your tongue coated (white, yellow, green or brown), especially in the morning?

☐ YES ☐ NO Do you have gastroparesis?

☐ YES ☐ NO Do you have a Hiatus Hernia?

☐ YES ☐ NO Do you have Colitis?

☐ YES ☐ NO Do you have Diverticulitis?

☐ YES ☐ NO Do you get or have Diarrhea?

GASTRO-INTESTINAL TRACT *continued from page 5*

☐ YES ☐ NO Do you get or have Constipation?

☐ YES ☐ NO Have you ever had stomach or intestinal ulcers?

☐ YES ☐ NO Do you or have you had any type of gastro-intestinal cancers? (stomach, colon, rectal, etc.)

→ Explain: _____

☐ YES ☐ NO Do you have Crohn's Disease?

☐ YES ☐ NO Do you have "gas" problems?

→ Other GI problems: _____

LIVER / GALLBALDDER / BLOOD

☐ YES ☐ NO Do you have a problem digesting fats?

☐ YES ☐ NO Do fats or dairy foods cause bloating and/or pain in the stomach area?

☐ YES ☐ NO Are your stools white, or very light brown in color?

☐ YES ☐ NO Do you get pain in the middle of your back (especially after eating)?

☐ YES ☐ NO Do you get pain behind the right, lower rib area?

☐ YES ☐ NO Do you have "liver" or brown spots on your skin? (not freckles)

☐ YES ☐ NO Are you Jaundiced (yellowing of the skin) or eyes?

☐ YES ☐ NO Do you have any skin pigmentation changes?

☐ YES ☐ NO Are you or have you ever been anemic?

☐ YES ☐ NO Do you have, or have you ever had, hepatitis? If so: **A** ☐ **, B** ☐ **, C** ☐ .

☐ YES ☐ NO Do you consume alcohol regularly? How often? _____

HEART AND CIRCULATION

☐ YES ☐ NO Do you get chest pains or angina?

☐ YES ☐ NO Have you ever had a heart attack (Myocardial Infarction)?

☐ YES ☐ NO Have you ever had open-heart surgery?

☐ YES ☐ NO Do you have heart arrhythmia's?
→ What kind? _____

☐ YES ☐ NO Do you ever feel pressure on your chest?

☐ YES ☐ NO Do you get "prickly" pains anywhere, especially in the heart area?
→ Where?_____

☐ YES ☐ NO Do you have, or have you ever had High Blood Pressure? (kidneys)

☐ YES ☐ NO Do you have a **Pacemaker** ☐ or **Stents** ☐ ?

SKIN

☐ YES ☐ NO Do you get or have skin rashes?

☐ YES ☐ NO Do you get skin blemishes?

☐ YES ☐ NO Do you have Eczema or Dermatitis?

☐ YES ☐ NO Do you have Psoriasis?

☐ YES ☐ NO Do you itch anywhere? Where?

☐ YES ☐ NO Is your skin dry?

☐ YES ☐ NO Is your skin excessively oily?

☐ YES ☐ NO Do you get or have dandruff?

☐ YES ☐ NO Do you have any other skin problems?

→ If so, what type? _____

☐ YES ☐ NO Do you have any tattoos? If so, where and how much of your body is covered?

→ _____

What is the approximate date of the most recent tattoo? _____

LYMPHATIC SYSTEM

☐ YES ☐ NO Do you have hair loss or are you bald or going bald?

☐ YES ☐ NO Have you ever had Lymph Nodes removed? Where and how many?

→ _____

☐ YES ☐ NO Do you have any gray hair?

☐ YES ☐ NO Do you have a hard time remembering things?

☐ YES ☐ NO Do you ever get colds or flu-like symptoms?

☐ YES ☐ NO Do you have fibromyalgia or scleroderma?

☐ YES ☐ NO Do you have sinus problems?

☐ YES ☐ NO Do you have or get sore throats?

☐ YES ☐ NO Do you have swollen lymph nodes?

☐ YES ☐ NO Do you have or have you had tumors?

→ If so, where?: _____

→ Type: **Fatty** ☐ **Benign** ☐ **Malignant** ☐

☐ YES ☐ NO Do you have a low platelet count (blood)?

☐ YES ☐ NO Have you had appendicitis or an appendectomy? When? _____

☐ YES ☐ NO Do you get boils, pimples, cysts, etc.?

☐ YES ☐ NO Do you get regular exercise? How many times per week? _____

→ What type of exercise? _____

☐ YES ☐ NO Have you ever had abscesses?

☐ YES ☐ NO Have you ever had toxemia?

☐ YES ☐ NO Do you have, or have you had, cellulitis? *(not cellulite – this is different!)*

☐ YES ☐ NO Have you ever had gout?

☐ YES ☐ NO Do you get blurred vision?

☐ YES ☐ NO Do you have mucus in your eyes when you wake up in the morning?

LYMPHATIC SYSTEM *continued from page 8*

☐ YES ☐ NO Do you snore?

☐ YES ☐ NO Do you have sleep apnea?

☐ YES ☐ NO Have you had your tonsils out? What age? _____

KIDNEYS AND BLADDER

☐ YES ☐ NO Have you ever had a urinary tract infection (UTI's)?

☐ YES ☐ NO Have you ever had "burning" upon urination?

☐ YES ☐ NO Do you have problems holding your bladder? (parathyroid)

☐ YES ☐ NO Have you ever had kidney stones?

☐ YES ☐ NO Do you have bags under your eyes (esp. in the morning)?

☐ YES ☐ NO Is your urine flow restricted?

☐ YES ☐ NO Do you get cramping or pain on either side of your mid-to-lower back?

☐ YES ☐ NO Do you or did you ever have nephritis?

☐ YES ☐ NO Do you have lower back weakness?

☐ YES ☐ NO Do you have or have you had sciatica?

☐ YES ☐ NO Do you or did you ever have cystitis?

LUNGS

☐ YES ☐ NO Do you get or have (or have had) bronchitis?

☐ YES ☐ NO Do you get or have (or have had) emphysema?

☐ YES ☐ NO Do you get or have (or have had) asthma?

☐ YES ☐ NO Do you get or have (or have had) C.O.P.D?

☐ YES ☐ NO Are you on inhalers or nebulizers? How often? _____

→ What medication? _____

→ Your oxygen saturation level is _____.

☐ YES ☐ NO Do you have pain when you breathe?

LUNGS *continued from page 9*

☐ YES ☐ NO Do you have pain when you take a deep breath? (adrenals)

☐ YES ☐ NO Is it difficult to take a deep breath?

☐ YES ☐ NO Did you ever or do you have lung cancer? When? _____

☐ YES ☐ NO Do you or did you have a collapsed lung? When? _____

☐ YES ☐ NO Are you a smoker?
→ How often? _____ Packs per day OR _____cigarettes per day

☐ YES ☐ NO Have you ever had pneumonia? When and how often? _____

☐ YES ☐ NO Have you ever worked around toxic chemicals, in coal mines or around asbestos?

☐ YES ☐ NO Do you cough a lot?

☐ YES ☐ NO Do you remove any mucus when you cough?
→ What color is the mucus? (clear, yellow, green, brown or black?) _____

ENVIRONMENTAL AND OTHER TOXINS

☐ YES ☐ NO Have you been vaccinated?

☐ YES ☐ NO Have you had shots for traveling to foreign countries?

☐ YES ☐ NO Have you had Flu shots?

☐ YES ☐ NO Do you have mercury Amalgams?

☐ YES ☐ NO Have you been exposed to nuclear wastes or by-products, heavy metals or chemicals?

☐ YES ☐ NO Have you had **radiation** ☐ or **chemotherapy** ☐ ?
→ If so, how many treatments? _____

☐ YES ☐ NO Have you ever used any form of recreational drugs? (this information is confidential and used to help you obtain optimal health only!)
If so, which drugs?
_____
→ Do you still use them? ☐ YES ☐ NO

CHEMICAL MEDICATIONS (List any chemical medications that you are presently taking)	
MEDICATION	**REASON FOR TAKING MEDICATION**
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆

NATURAL SUPPLEMENTS *(List any natural supplements you are taking)*	
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆
◆	◆

ALLERGIES *(List anything that you are allergic to)*

PAST SURGERIES *(List any surgeries you have had, minor and major along with the year)*	
1)	7)
2)	8)
3)	9)
4)	10)
5)	11)
6)	12)

GENETIC/FAMILY HISTORY *(List the health issues – if known – of each family member)*
Mother:
Father:
Maternal Grandmother:
Maternal Grandfather:
Paternal Grandmother:
Paternal Grandfather:
Sibling:
Sibling:
Sibling:
Sibling:

WHAT ARE YOUR MAJOR HEALTH COMPLAINTS OR CONCERNS?
Please list any conditions or symptoms that were not covered in this questionnaire.