



Health Survey

Name: _____

Date: _____

Current concern:

How long have you had your concern?

What makes it better?

What makes it worse?

Are you now (○) using or have you in the past (P) used any of the following to maintain or improve your health?

- | | |
|---|--|
| <input type="radio"/> P Acupuncture | <input type="radio"/> P Medication |
| <input type="radio"/> P Aromatherapy | <input type="radio"/> P Movement or dance |
| <input type="radio"/> P Art or creative therapy | <input type="radio"/> P Physical therapy |
| <input type="radio"/> P Ayurvedic medicine | <input type="radio"/> P Prayer or meditation |
| <input type="radio"/> P Biofeedback | <input type="radio"/> P Relaxation techniques |
| <input type="radio"/> P Chiropractic | <input type="radio"/> P Special diet |
| <input type="radio"/> P Counseling or psychotherapy | <input type="radio"/> P Spiritual or energetic healing |
| <input type="radio"/> P Herbs | <input type="radio"/> P Vitamins/supplements |
| <input type="radio"/> P Homeopathy | <input type="radio"/> P Writing/journaling |
| <input type="radio"/> P Hypnosis | <input type="radio"/> P Yoga |
| <input type="radio"/> P Massage Therapy | <input type="radio"/> P Other: _____ |