This package has been designed to assist you through the process of achieving your personal wellness goals. Please read carefully and bring a completed hard copy (or email me a scanned soft copy) of the Health History Form (pages 6-10) to your first visit.

Congratulations on taking this first step on your journey to optimal health. Personal wellness is a lifestyle choice and I am here to be your guide.

You may be reaching out to improve energy and vitality, recover from a specific illness or health concern, seek out natural alternatives or ways to complement your current prescriptions/treatments, prevent disease, and/or bring the body back into balance. Whatever your reason is, be prepared for a journey that can change your life for the better, permanently.

A Naturopath works to seek out the root cause of your symptoms using therapies that support the healing power of the body and nature that do not suppress your symptoms.

My intention is to guide you on your healing journey so that you can live life to your fullest potential.

Services

My services include: clinical nutrition, homeopathic medicine, herbal medicine, acupuncture, vitamin and mineral therapies, lifestyle counseling, hydrotherapy, drainage and detoxification.

Naturopathic Medicine can benefit the whole family. I treat all ages, including: infants, children, teens, adults and seniors.

Please follow me for regular health tips, articles and recipes on:
Twitter: @drlisaweeksND
Facebook: www.facebook.com/DrLisaWeeksNaturopathicDoctor
LinkedIn: ca.linkedin.com/pub/lisa-weeks/5/aa4/a40/

If, after several visits, you are happy with my services, please feel free to refer your friends, family members and co-workers. I am currently accepting new patients.
Frequently Asked Questions

What are some reasons to see a Naturopathic Doctor?
- You are sick of feeling sick
- You are looking to complement your existing medical treatments
- You are not feeling your best but are unsure why
- You want a simple yet effective exercise and nutrition plan
- You are worried about and want to prevent diseases that run in your family to be proactive about your health
- You are working towards a specific health goal that you want to achieve.

What conditions can benefit from Naturopathic Medicine?
**Digestive:** IBS, GERD/acid reflux/heartburn, diarrhea, constipation, gas, bloating, inflammatory bowel diseases, parasites, Candida, hemorrhoids, fissures
**Immune:** autoimmune conditions, allergies, colds, flus, sore throats, ear infections, lung infections, urinary tract infections
**Skin:** eczema, psoriasis, acne, hives, dry skin, anti-aging, rashes, fungal infections
**Pain:** arthritis, injuries, strains, sprains, headaches, migraines, neck-pain, back pain, stress-related pain
**Hormonal Imbalances:** PMS, menopause, infertility (males and females), andropause, stress, thyroid conditions
**Sleep Disorders:** insomnia, trouble falling or staying asleep, not waking rested, restless sleep
**Fatigue:** exhaustion, burnout
**Mood Disorders:** depression, anxiety, seasonal affective disorder
**Pediatric Health:** immune disorders, frequent illnesses, skin conditions (eczema, diaper rash), digestive issues, sleep disorders, ADHD/ADD
**Disease Prevention and health optimization**

How can Naturopathic Medicine help me if I am already healthy?
Much like a car gives you warning signs when the oil needs to be changed, your own body gives you warning signs before things start to shutdown or malfunction. Naturopathic Medicine recognizes these symptoms and determines the underlying cause of disease, treating the problem before it becomes more serious.

How is a Naturopathic Doctor trained?
Naturopathic Doctors (NDs) must complete at least 3 years of pre-medical sciences in University before completing the four-year full-time Naturopathic Medicine program from one of six accredited Naturopathic Colleges in North America. The Naturopathic program includes over 4200 hours of classroom training, over 1200 hours of supervised clinical training and studies in bio-medical sciences and naturopathic modalities. NDs must successfully pass 2 intensive licensing exams and obtain yearly continuing medical education credits.

What can I expect during a visit to a Naturopathic Doctor?
- **Initial Visit** – 90 minutes (adults); 60 minutes (kids)
  - Includes a discussion about your health concerns and goals, a review of your health history, a thorough physical examination and a Chinese medicine tongue and pulse diagnosis.
- **Second Visit** – 60 minutes
  - Held approximately two weeks after your initial visit. We will review your complete personalized treatment protocol.
- **Third Visit** - 45-60 minutes
  - Held approximately four weeks after your second visit. This visit is important as it is a chance to check in, make sure that the treatment protocol is understood and being followed, and to monitor any changes that may have occurred.
- **Follow-up Visits** – 45-60 minutes
  - Conducted monthly, but may vary depending on the concern and the treatment plan decided on. As you progress on your treatment plan, you may only need to book in for an appointment every few months.

**NOTE:**
- Dr. Weeks is also available for follow-up appointments via Skype or by phone. The initial visit must be conducted in-person.
What can I expect during an acupuncture visit to a Naturopathic Doctor?

**Initial Visit** – 90 minutes
We will review your health concerns, I will perform a basic physical examination including a Chinese medicine tongue and pulse diagnosis, and you will receive a 20-minute initial acupuncture treatment.

**Follow-up Visits - 30-45 minutes**
Visits are typically conducted once a week for 4-6 weeks, depending on the severity and duration of your health concern. After the initial 4-6 week appointments, maintenance treatments are typically conducted every 2-4 weeks depending on your health condition.

**NOTES:**
- If you are suffering from an acute illness, like a cold, flu, sore throat, headache or infection, you can book in for a short visit, phone or Skype appointment to help you recover quicker and reduce the chance that you will need antibiotics or medications.
- Seasonal visits are also recommended for detoxification in the fall and spring, immune support in the fall/winter and treatment for allergy prevention in the spring/summer.
- A yearly physical exam and blood/lab test review is recommended to schedule with your Naturopathic Doctor. NDs can order blood tests or fax an “Authorization for Release of Records” form to your MD to receive your most recent results.

**Appointment Booking**

You can reach me by email (lisaweeks.nd@gmail.com) or by phone (647-667-2209) to schedule an appointment.

**Naturopathic Fees**

*As of Feb 12, 2014, NDs are no longer required to charge HST on Naturopathic visits. HST still applies to supplement sales and lab tests*

<table>
<thead>
<tr>
<th></th>
<th>Adults</th>
<th>Kids &lt; 12</th>
<th>Acupuncture</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90 minutes</td>
<td>60 minutes</td>
<td>90 minutes</td>
</tr>
<tr>
<td>Initial Consultation:</td>
<td>$190</td>
<td>$160</td>
<td>$190</td>
</tr>
<tr>
<td>Second Visit:</td>
<td>$140</td>
<td>$140</td>
<td>$75</td>
</tr>
<tr>
<td>Subsequent Visits:</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Subsequent Visits:</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
</tbody>
</table>

**Payment**

You can pay by cash, cheque or email transfer for Naturopathic visits, NOT credit/debit. Cheques can be made payable to “Lisa Weeks”. Email transfers can be made to lisaweeks.nd@gmail.com.

**24 Hour Cancellation Policy**

I have a policy of 24-hrs notice. If I do not receive 24-hrs notice of cancellation, you will be invoiced for the full appointment fee. Please respect my time and let me know if you can’t make an appointment.
Introduction to Naturopathic Medicine

Your Naturopathic Doctor can draw from a wide range of therapies, and will develop a treatment plan specially designed for you. The most common modalities, which may be used individually or in combination, are described below:

Herbal (Botanical) Medicine
Medicines derived from plants have been used for centuries in the treatment and prevention of disease. They are increasingly becoming the subject of a growing number of clinical research studies. While the active ingredients of some plant medicines are extremely powerful, they are safe and highly effective when administered by a trained Naturopathic Doctor.

Clinical Nutrition
There is an intrinsic relationship between nutrition and wellness. Naturopathic Doctors deal with a wide range of problems relating to poor nutrition, including food sensitivities or reactions and factors that interfere with the body’s absorption and utilization of vitamins and minerals. They can also diagnose and treat numerous conditions that result from nutrient deficiencies.

Traditional Chinese Medicine and Acupuncture
Chinese pulse and tongue diagnosis, acupuncture, and the use of eastern botanical medicines comprise Asian Medicine, a system of health care that has been used effectively for thousands of years in Asia, but which has only been introduced to North America in the 20th century. Naturopathic Doctors complete over 300 hours of acupuncture training as part of their Naturopathic Medical degree. Small, sterile, non-reusable needles are inserted into specific points on the body and have been clinically tested in the treatment of headaches, pain and muscle tension, infertility, nausea, stress/anxiety, addictions to nicotine; caffeine; and other drugs, and to rebalance the body.

Homeopathic Medicine
Originally developed during the 18th century by the physician Samuel Hahnemann, this unique form of medicine is used widely by medical practitioners in Europe but is just beginning to take hold in North America. Homeopathic medicine uses very dilute amounts of botanical, mineral, or other substances to treat specific ailments.

“An ounce of prevention is worth a pound of cure.” - Benjamin Franklin

Hydrotherapy and Physical Medicine
Hydrotherapy, or the stimulation of blood and lymphatic fluid circulation using hot and cold water, is also prescribed to patients extensively for boosting immune function and supporting detoxification, skin health, and overall vitality. Naturopathic Doctors are trained in the assessment and treatment of musculoskeletal disorders such as joint pain, back pain, neck pain, muscle tension, injuries, strains, and sprains and commonly work with physical therapists, chiropractors, massage therapists, and osteopathic doctors to support the healing process.

Lifestyle Counseling
The foundations of health are clean air, clean water, exercise, healthy foods, and freedom from excess stress. Naturopathic Doctors are committed to educating and guiding their patients in making powerful positive lifestyle changes to achieve optimal health. Whatever your diagnosis, you can expect to receive some lifestyle counseling every time you visit a Naturopathic Doctor. Daily healthy habits including reducing stress and negative emotions will positively influence your health and contribute to your success.

Supplementation and Dietary Review/Counseling
You are what you eat! Through tracking your food via a food journal and testing for food sensitivities and vitamin deficiencies, your Naturopathic Doctor will ensure you are getting the right foods and supplements to fuel your body. You will be provided with nutritional guidelines that are unique to you and your health concerns.

Disease Prevention
By reviewing your family’s health history, your Naturopathic Doctor can give you nutritional, supplemental, lifestyle, and herbal recommendations to help prevent or reduce symptoms of certain diseases. In addition, your Naturopathic Doctor can order and monitor certain blood values to ensure you are on the right path to prevention.
Additional Naturopathic Services

(Fees apply: not covered by OHIP)

Online Naturopathic Dispensary
I offer an online Naturopathic dispensary for you to purchase your vitamins, herbs and supplements. This saves you time and money (prices are competitive with local health food stores). Shipping takes approximately 3-4 days. [https://healthwavehq.ca/welcome/lweeks](https://healthwavehq.ca/welcome/lweeks)

Nebulized Glutathione
A non-invasive, effective inhalation therapy used for upper and lower respiratory tract infections, bronchitis, allergies, the common cold, lung repair after quitting smoking, chronic mucous/congestion and COPD. An essential part of any detoxification plan as glutathione is a powerful detoxifying agent.

B12 Injections
An intramuscular injection in your upper arm or buttocks to boost energy levels, replace deficiencies, reduce numbness and tingling, and support memory, mood and concentration.

Pascoleucyn Immune Booster Drink
A safe and effective natural immune booster to be given in the fall and winter to prevent or reduce recovery time of illnesses. With over 60 years of use, this herbal and homeopathic combination provides broad-spectrum support against viruses and bacteria by boosting immunity.

Lab testing
An important part of your Naturopathic assessment: includes blood, urine and stool testing to determine food sensitivities (IgG), male/female/thyroid and stress hormone levels, nutrient deficiencies, digestive disorders and parasites.
Adult Naturopathic Health History Form

LISA WEEKS HBSc., ND

Date: _____/_____/____ (DD/MM/YY)

Name: ______________________________________________________________________________________

Date of birth: _____/_____/____ (DD/MM/YY) Age: _______ Sex: (circle one) M / F

Address: ______________________________________________________________________________________

City: ___________________________ Postal code: ___________________________

Telephone: (Home) (_____ )________-________ (Work) (_____ )________-________

Email: ______________________________________________________________________________________

Marital status: (circle one) Single Married Divorced Separated Other: (please specify):____________________

May we send clinic-related information to your mailing/email address? Y / N Initial: ________________

May we leave voice-mail messages related to your visits? Y / N Initial: ______________________________

Emergency Contact: Name: __________________________________________________________________

Telephone: (_____ )________-________ Relation: ______________________________

How did you hear about our Clinic? ___________________________________________________________________

Other HEALTH CARE PROVIDERS you are seeing:

1. ___________________________________________________________________________________________

2. ___________________________________________________________________________________________

3. ___________________________________________________________________________________________

4. ___________________________________________________________________________________________

5. ___________________________________________________________________________________________

6. ___________________________________________________________________________________________

7. ___________________________________________________________________________________________

8. ___________________________________________________________________________________________

Please list your PRIMARY HEALTH CONCERNS, in order of importance to you:

1. ___________________________________________________________________________________________

2. ___________________________________________________________________________________________

3. ___________________________________________________________________________________________

4. ___________________________________________________________________________________________

5. ___________________________________________________________________________________________

6. ___________________________________________________________________________________________

7. ___________________________________________________________________________________________

8. ___________________________________________________________________________________________

Health History

How would you describe your overall state of health? (circle one) Very poor Poor Fair Good Very good Excellent

List any SERIOUS MEDICAL CONDITIONS, DIAGNOSES AND/OR ILLNESSES: (including type and year of occurrence).

<table>
<thead>
<tr>
<th>Condition/Diagnosis/Illness</th>
<th>Month/Year</th>
<th>How does this still affect you?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List any ACCIDENTS, INJURIES, SURGERIES AND/OR HOSPITALIZATIONS (including type and year of occurrence).

<table>
<thead>
<tr>
<th>Accident/Surgery/Hospitalization</th>
<th>Month/Year</th>
<th>How does this still affect you?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
List any known ALLERGIES (including food, drugs, insects, herbs, environmental).

Have you ever seen a Naturopathic Doctor before? Y / N If yes, for what reason?

What other treatments have you used, or are currently using (both conventional and alternative; ie. Chiropractic, Physiotherapy, Massage, etc.)

Do you have any of the following?

|-----------------------------|------|-------------------|-------------|------|-------------------|---------------------|------|--------------------------|------|-------------|------|

Which of the following conditions apply to you? N = Now    P = Past    X = Never

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Anemia</th>
<th>Hay fever</th>
<th>Emphysema</th>
<th>Palpitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chills</td>
<td>Dizziness</td>
<td>Nose bleeds</td>
<td>Pleurisy</td>
<td>Rheumatic fever</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Headache</td>
<td>Sinusitis</td>
<td>Pneumonia</td>
<td>Change in thirst/appetite?</td>
</tr>
<tr>
<td>Fever</td>
<td>Cataracts</td>
<td>Goiter</td>
<td>Shortness of breath</td>
<td>Gall stones</td>
</tr>
<tr>
<td>Weakness</td>
<td>Eye problems</td>
<td>Neck Pain</td>
<td>Tuberculosis</td>
<td>Heartburn</td>
</tr>
<tr>
<td>Change in mole</td>
<td>Glasses or contacts</td>
<td>Sore throat</td>
<td>Angina or chest pain</td>
<td>Hemorrhoids</td>
</tr>
<tr>
<td>Night Sweats</td>
<td>Glaucoma</td>
<td>Swollen glands</td>
<td>Diabetes</td>
<td>Jaundice</td>
</tr>
<tr>
<td>Rash</td>
<td>Ear infections</td>
<td>Asthma</td>
<td>Heart disease</td>
<td>Liver disease</td>
</tr>
<tr>
<td>Skin cancer</td>
<td>Impaired hearing</td>
<td>Bronchitis</td>
<td>High blood pressure</td>
<td>Ulcer</td>
</tr>
<tr>
<td>Skin problems</td>
<td>Frequent colds</td>
<td>Cough</td>
<td>Murmurs</td>
<td>Kidney stones</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Backache</td>
<td>Muscle spams or cramps</td>
<td>Extremities</td>
<td>Kidney disease</td>
</tr>
<tr>
<td>Varicose veins</td>
<td>Painting</td>
<td>Loss of balance</td>
<td>Loss of memory</td>
<td>Muscle weakness</td>
</tr>
<tr>
<td>Paralysis</td>
<td>Seizures or convulsions</td>
<td>Speech problems</td>
<td>Anxiety</td>
<td>Depression</td>
</tr>
<tr>
<td>Phobias</td>
<td>Chicken pox</td>
<td>Cold sores</td>
<td>Influenza</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>Malaria</td>
<td>Measles</td>
<td>Mononucleosis</td>
<td>Mumps</td>
<td>Parasites</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>Herpes Genitalia</td>
<td>Sexually Transmitted Dz</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please indicate what immunizations you have had (check all that apply):

- DPT (diphtheria, pertussis, tetanus)
- MMR (measles, mumps, rubella)
- Haemophilus influenza B
- Hepatitis A
- Tetanus booster
- Smallpox
- Hepatitis B
- Influenza (“Flu shot”)
- Polio
- Other __________________________

Did you experience any adverse reactions to past immunizations? Y / N If yes, what was the reaction/side effects?

Have you traveled outside of Canada in the past year? __________________________

Do you get regular screening tests done by another doctor (Pap, blood tests): Y / N
Women’s Health

Are you currently on the Birth Control Pill? Y / N  Brand? ___________  Length of time on the Pill? ___________

Age of first period _______  Last menstrual period __________

Length of monthly cycle (days) _______  Average length of flow (days) _______

Last PAP exam (days)_____________  Have you had an abnormal PAP? Y / N

Last breast exam ____________  Do you do self breast exams? Y / N

Age of onset of menopause (if applicable): _______  Symptoms? ____________________________

Are you currently sexually active? Y / N

Current forms of contraception? ____________________________

Number of: pregnancies? _______  Live births? _______  Miscarriages? _______  Abortions? _______

Have you had any of the following concerning your breasts? (circle)  Pain      Lumps      Infections      Cysts      Nipple discharge

Do you have any sexual problems or concerns? Y / N  If yes, explain: __________________________

Are you currently pregnant? Y / N

Men’s Health:

Do you have difficulty achieving or maintaining an erection? Y / N

Last prostate exam? _______  Was a blood test (PSA) done? Y / N

How many times a night do you wake to urinate? _______

Have you had any of the following symptoms with urination? (circle one)  Pain  Dribbling  Incomplete  Urgent  Increased frequency

Are you currently sexually active? Y / N

Current forms of contraception? ____________________________

Have you had any of the following? (circle one)  Testicular pain  Hernia  Penile discharge  Sores  STDs

Do you have any sexual problems or concerns? Y / N  If yes, explain: __________________________

Medication History

Medications:
Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Daily dose</th>
<th>How long</th>
<th>Medication</th>
<th>Daily dose</th>
<th>How long</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td>4.</td>
<td></td>
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<tr>
<td>2.</td>
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<td>5.</td>
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<td></td>
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<tr>
<td>3.</td>
<td></td>
<td></td>
<td>6.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Supplements:
Please list all current vitamins, minerals, herbs, homeopathics or other supplements, the daily dose and how long you have taken it.

<table>
<thead>
<tr>
<th>Supplement</th>
<th>Daily dose</th>
<th>How long</th>
<th>Supplement</th>
<th>Daily dose</th>
<th>How long</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<td>4.</td>
<td></td>
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<tr>
<td>2.</td>
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<td></td>
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<tr>
<td>3.</td>
<td></td>
<td></td>
<td>6.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please list all past prescription medications and supplements.
____________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________

How many courses of antibiotics have you had in the past 10 years? ________________________________

Have you ever had a bad reaction to any medication or supplement? ________________________________

Family Health History

Indicate if a close relative (parent, grandparent, sibling or child) has had any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Who?</th>
<th>Condition</th>
<th>Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td>High blood pressure</td>
<td></td>
</tr>
<tr>
<td>Alcoholism</td>
<td></td>
<td>High cholesterol</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td>Kidney Disease</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>Mental illness</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>Osteoporosis</td>
<td></td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td></td>
<td>Rheumatic fever</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td>Skin diseases</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Emphysema</td>
<td></td>
<td>Thyroid condition</td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

☐ I don’t know my family medical history

Has any family member passed away (parents, siblings, grandparents?)  Y / N
If yes, who_________________________; age_______; how?_______________________________________

Diet

Have you LOST / GAINED any weight lately?  Y / N  If yes, how much? ______________

Please describe a typical day’s diet

Breakfast ____________________________________________
Lunch _____________________________________________
Dinner _____________________________________________
Snacks _____________________________________________
Beverages __________________________________________

How many glasses of water do you drink per day?______________

Is your drinking water (circle):  Tap      Bottled      Filtered      Other:____________

Do you have any food allergies or sensitivities? Please list.__________________________________________

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? _____________________________
Lifestyle / Environment

Occupation ____________________________________________________________

How stressful is your work or other aspects of your life? How do you handle these stresses? ____________________________________________________________

Are you regularly exposed to toxins or other hazardous substances (work, home, hobbies, etc.)? Please describe. ____________________________________________________________

Are you frequently exposed to animals (at work, home, etc.)? Y / N

Please indicate which of the following substances, if any, pertain to you. N= use NOW  P= used in the PAST

<table>
<thead>
<tr>
<th>Substance</th>
<th>N / P</th>
<th>Amount</th>
<th>Started?</th>
<th>Substance</th>
<th>N / P</th>
<th>Amount</th>
<th>Started?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
<td></td>
<td>Soda</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coffee</td>
<td></td>
<td></td>
<td></td>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black Tea</td>
<td></td>
<td></td>
<td></td>
<td>Recreational Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appetite suppressants</td>
<td></td>
<td></td>
<td></td>
<td>Sleeping pills</td>
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</tr>
</tbody>
</table>

Are you frequently exposed to tobacco smoke (home, work)? ____________________________________________________________

Have you ever been treated for alcohol/drug dependence? Y / N  If yes, when? __________________________________________

How often do you participate in physical activities/exercise? (circle one) Daily 2-3X/week 4-5X/week Daily less than 1X/week

What types of activities/exercise? ____________________________________________________________

How many hours of television do you watch in a day? ________ Do you have a television in your bedroom? Y / N

What are your hobbies? What do you enjoy in life? ____________________________________________________________

How would you describe the emotional climate of your home? ____________________________________________________________

How would you rate your overall level of energy? (1=poor, 10=excellent) ________________

How many hours of sleep do you get per night? ________

How would you rate your overall quality of sleep? (1=poor, 10=excellent) ________________

Do you have trouble falling asleep? Y / N  Staying asleep? Y / N

Do you awake rested? Y / N

Is there anything else you feel I should know? ____________________________________________________________

THANK YOU for taking the time to fill out this form. The information provided will be used to assess your health care needs.