

Health Assessment Form

Name (Mr./Miss/Mrs.).....Middle name.....Last name.....
 Date of birth.....City of birth.....Time of birth.....
 Height.....feet / centimeters Weight.....pounds / kilograms
 Blood group.....Blood pressure.....Heart beating.....time/minute
 ID number.....Occupation.....
 Postal address.....
 City.....Post code.....Country.....
 Contact number.....E-mail address.....
 Marital status : Single Married Separated Year of your marriage.....
 Number of children.....Child.....Daughter.....

How often did you have the following illness symptoms?

1. Headache one side both sides whole head tingling headache
2. Shoulder pain left right
3. Waist pain left right
4. Neck pain left right
5. Hip pain left right
6. Backache left right
7. Calf Pain left right
8. Difficulties in urination
9. Feel hot and cold
10. Difficulties in sleeping
11. Easily tensed
12. Easily upset
13. Easily sorrow
14. Easily dazed
15. Easily worried
16. Hard to decide
17. Food boring
18. Squeamish
19. Did you have any following eye symptom?
 blurred painful irritation double vision stinging
 often painful when..... often tearing when.....
20. Did you have any following ear symptom?
 often hearing loud voice difficult in hearing
 ear pain having a ringing in one's
 water in ear

21. Did you have any following nose symptom?
 sneeze in morning difficult to breath snot
 pain in nose whole left right
22. Did you have any following chest symptom?
 left pain right pain high frequency beating epigastria pain
 easily alarmed sweat in hand
23. Often flatulent
24. Gassy & Regurgitation
25. Back pain + Dizziness
26. Thigh pain left right
27. Abdominal pain left right
28. Knee pain left right
29. Did you have any skin allergy?
 yes flower essence insect other.....
 no
30. Did you have any surgery before? no yes which area.....
31. What is your favorite hobby?
 travel singing reading drinking gambling
 games sport cooking others.....
32. Did you normally practice mediation?
 yes morning afternoon Evening before bed anytime
 no
33. Did you normally dream when sleeping?
 yes good dream nightmare tensed fear
 no
34. What time do you normally sleep?
- What time do you normally wake-up in the morning?
35. What is your drinking behavior?
 drinking coffee.....cup/day tea.....cup/day
 aerated.....bottle/day tonic.....bottle/day
 alcohol.....bottle/day
 caned food.....can/day pasteurized.....meal/day
36. Where do you normally have your meal?
 at restaurantmeal/week at home.....meal/week
 delivery.....meal/week fast food.....meal/week
37. What is your consuming behavior?
 meat > vegetable vegetable > meat meat only vegetarian
38. What is your favorite taste?
 sweat sour salty insipid strong spicy

Please send this form back to our Vitruvial Consulting's specialists for your **FREE** health assessment at our e-mail: health@vitruvial.com or Fax no. +66 2 -732 9628. We will provide you back a brief summary of your health focus. Search for more healthcare consulting services for good health, please click <http://www.vitruvial.com/services.htm>.