

The Magic of Energy Medicine Centre
Rockhampton 0407 229 302

Present state of habits

Date: _____

Name: _____ Occupation _____

Address _____ Email _____

Ph: W _____ H: _____ Mobile: _____

B/fast: _____

Lunch: _____

Evening Meal: _____

Snacks: Morning: _____ Afternoon: _____ Evening: _____

Fluids

How many cups of tea do you drink daily? _____ Coffee: _____ Other: _____

How many sugars or sweeteners do you have in tea _____ Coffee: _____ Other: _____

Do you have milk in tea? Yes _____ No _____ Coffee: Yes _____ No _____

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

HABITS DRUGS AND SUPPLEMENTS

Are you a Shift worker? _____ Type of shifts _____

Sleep: How many hours nightly _____ I retire at _____ I arise at _____

Do you watch TV? How many hours per day _____ On computers _____ Internet _____

Do you exercise? Daily _____ twice or more weekly _____ weekly _____ occasionally _____

Do you smoke? Yes _____ No _____ How many per day _____ How long have you smoked _____

Do you consume alcohol? Yes _____ No _____ Daily _____ More than twice weekly _____ Weekends only _____

Occasionally _____ Never _____

What drugs or antibiotics are you presently taking (include dosage)

EXERCISE

Do you exercise? Yes: _____ No: _____ Occasionally _____

Once a week _____ Twice a week _____ More than twice weekly _____ Weekends only _____

Describe your exercise: _____

How many hours or minutes do you exercise in a week? _____

Do you participate in competitive sports? _____

CHEMICALS

Do you work with chemicals? Yes _____ No _____

Type of Chemicals _____

FAMILY

Children:

Name/s DOB (age)

Schedule:

On waking: _____

Morning: _____

Lunch: _____

Evening: _____

Main reason for visit:
