DinaLahlou

The Holistic Detox Questionnaire

1. Name: _

2. Age: _

3. Sex:

☐ Male ☐ Female

4. Familial status:

☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Single

5. Professional activity _

6. Do you have children?

☐ Yes ☐ No If yes, how many? _ _ _ _ _ _ _ _ _ _ _ _

7. Are you pregnant or planning to get pregnant in the coming year?

☐ Yes ☐ No If pregnant, how many weeks/months? _ _ _ _

8. Are you an only child?

☐ Yes ☐ No If no, how many Brothers _ _ _ how many Sisters _ _ _

9. Are you the

☐ Eldest ☐ Middle ☐ Youngest

10. Have you experienced in the past 18months an emotional challenge?

If yes, please briefly describe it:

_ _

_ _

_ _

11. Are you satisfied with your actual physical health?

☐ Yes ☐ No If no, what would you like to change?

12. Do you have a particular medical condition?

☐ Yes ☐ No If yes, please briefly describe it:

13. Do you take any medication?

☐ Yes ☐ No If yes, what? Why and since when?

14. Do you have any allergies to any particular food?

☐ Yes ☐ No If yes, to what?

15. Are you a smoker?

☐ Yes ☐ No If yes, how many cigarettes a day? Since when?

16. Do you drink alcohol?

☐ Yes ☐ No If yes, what? How often & since when?

17. Is there any food, you do not like, or you prefer not to eat?

☐ Yes ☐ No If yes, What? Why?

18. What are your favorite vegetables besides potatoes and tomatoes?

19. Do you eat sweets?

☐ Yes ☐ No If yes, how regularly? What? How often?

20. Do you drink coffee?

☐ Yes ☐ No If yes, how often per day or week? Morning or Afternoon?

21. Do you eat red meat?

☐ Yes ☐ No If yes, how many times a week/month?

22. Do you eat white meat besides fish?

☐ Yes ☐ No If yes, how many times a week/month?

23. Do you eat fried food? (Fish, French fries etc.)

☐ Yes ☐ No If yes, how many times per week/month?

24. What is your habitual sleep cycle? (Average hours/night)

25. Do you fall asleep with difficulty?

☐ Yes ☐ No If yes, why so?

26. Do you take sleeping pills?

☐ Yes ☐ No If yes, how often? Why? What?

27. What do you usually do before you fall asleep?

28. Do you Watch TV before you sleep?

☐ Yes ☐ No If yes, how many hours a week do you watch TV? (Average)

29. Do you have difficulties waking up?

☐ Yes ☐ No If yes, why do you think that is?

30. Do you take time upon waking up before starting your activities or do you 'jump out' of bed? Do you feel rested after your sleep?

31. Would you say that you are a morning person or a night person?

32. Are you sexually and regularly active?

33. Do you practice any kind of physical activity? (Gym, walking, running, team games, etc.)

☐ Yes ☐ No If yes, which one, and how regularly?

34. Do you have physical complaints or aches on a regular basis? (Back, head, stomach acidity, joints pains, etc)

☐ Yes ☐ No If yes, which ones?

35. Do you take painkillers?

☐ Yes ☐ No

36. How much time do you spend in front of a computer/internet? (Hours per day or per week).

37. Why would you like to go on a detox program