

Suzanne Peppell, N.D.  
Phone: 610.759.7001

1457 Hildenbrandt Road  
Wind Gap, PA 18091

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

\_\_\_\_\_ Phone (work) \_\_\_\_\_

E-mail \_\_\_\_\_ Phone (cell) \_\_\_\_\_

I prefer to be contacted:  at home  at work  cell phone  doesn't matter

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Occupation \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Please list your current  
health concerns.

How long  
have you  
had this  
problem?

How are you currently treating  
this problem?  
Include both doctor-prescribed  
& self treatments.

1. 1.

2. 2.

3. 3.

Who may I thank for referring you? \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

List all food, drug, and environmental ALLERGIES you have.

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List all HOSPITALIZATIONS and SURGERIES. Include dates.

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List ALL prescription & over-the-counter MEDICATIONS you are currently taking.

Medication	Amount
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you . . .

Feel safe at home?	Yes	No
Have a gun in the house?	Yes	No
Use recreational drugs?	Yes	No
Enjoy your work?	Yes	No

When was the last time you saw a . . .

Primary care doctor?	_____
Dentist?	_____
Eye doctor?	_____
Gynecologist?	_____

Is there a FAMILY HISTORY of the following?

	Who?		Who?
Cancer	_____	Diabetes	_____
Heart disease	_____	Mental illness	_____
Stroke	_____	Allergies/Hayfever	_____
Alcoholism	_____	Thyroid disease	_____
Liver disease	_____	Gallbladder disease	_____
Arthritis	_____	High blood pressure	_____
Anemia	_____	Kidney disease	_____



# Healthy Living Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Gender:  Male  Female

Current Weight: \_\_\_\_\_

Do you consider yourself:

underweight  overweight  just right

Unintentional weight loss or gain of 10 pounds or more in the last three months: Yes  No

Recent changes in your ability to:

see  hear  taste

smell  feel hot/cold sensations

## 1. Check the Following Statements That Apply:

- Occasionally or frequently skip meals
- Suffer from fatigue
- Currently overweight
- Crave sweets or carbohydrates
- Crave stimulants, such as caffeine or soft drinks
- Suffer from chronic pain
- Suffer from headaches

## 2a. Activity Level – Check Your Current Level of Work or Lifestyle:

- Level 1 – Very Light Work:** Sitting, standing, driving, reading, computer, etc.
- Level 2 – Light Work:** Light housework, labor, childcare, mechanic, some sitting, etc.
- Level 3 – Moderate Work:** Heavy gardening, housework, labor, no sitting, etc.
- Level 4 – Heavy Work:** Heavy manual labor, construction, digging, etc.

## 2b. Exercise Level – Check Your Current Level of Exercise:

- None
- Level A – Light Exercise:** 1-3 times per week, easy pace, stretching, walking, etc.
- Level B – Moderate Exercise:** 2-3 times per week, moderate pace, some weights, etc.
- Level C – Heavy Exercise:** 3-4 times per week, vigorous pace, weights, fast running, etc.

## 3. Balance Eating – Check Which Apply:

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt Restriction
- Fat Restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions of:
  - dairy  wheat  eggs
  - soy  corn  all gluten
- Other \_\_\_\_\_

### Servings per day:

Fruits (citrus, melons, etc.) \_\_\_\_\_

Dark green or deep yellow/orange vegetables \_\_\_\_\_

Grains (unprocessed) \_\_\_\_\_

Beans, peas, legumes \_\_\_\_\_

Dairy, eggs \_\_\_\_\_

Meat, poultry, fish \_\_\_\_\_

## 4. Eating Frequency – Check Which Apply:

- Skip breakfast or other meals \_\_\_\_\_
- Three meals/day
- Two meals/day
- One meal/day
- Graze-small frequent meals (how many/day) \_\_\_\_\_
- Generally eat on the run

## 5. Exercise Frequency and Schedule – Check Which Apply:

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 min or more duration per workout
- 30-45 min or more duration per workout
- Less than 30 min
- Use of personal trainer
- Member of fitness club
- Own exercise equipment
- Walk: days/week \_\_\_\_\_
- Run, jog, jump rope, other aerobic: days/week \_\_\_\_\_
- Weight lift: days/week \_\_\_\_\_
- Stretch: days/week \_\_\_\_\_
- Yoga: days/week \_\_\_\_\_
- Other \_\_\_\_\_ days/week \_\_\_\_\_

# Healthy Living Questionnaire~Page 2

## 6. Stimulant Use Habits – Check Which Apply:

- Tobacco:
  - Cigarettes: #/day \_\_\_\_\_
  - Cigars: #/day \_\_\_\_\_
  - Pipe: #/day \_\_\_\_\_
- Alcohol:
  - Wine: # glasses/day or week \_\_\_\_\_
  - Liquor: # ounces/day or week \_\_\_\_\_
  - Beer: # glasses/day or week \_\_\_\_\_
- Caffeine:
  - Coffee: # of 6 oz cups/day \_\_\_\_\_
  - Tea: # of 6 oz cups/day \_\_\_\_\_
  - Soda w/caffeine: # of cans/day \_\_\_\_\_
  - Soda w/o caffeine: # of cans/day \_\_\_\_\_
  - Other sources \_\_\_\_\_
- Water:
  - # glasses/day \_\_\_\_\_

## 9. Energy – Vitality

- I'd like to:
- Have more energy
  - Have longer endurance
  - Have more motivation
  - Sleep better
  - Be less tired after lunch
  - Feel more vital
  - Regain vitality and vigor of my younger years
  - Get less colds and flu
  - Get rid of allergies
  - Not use so many over the counter drugs
  - Stop using laxatives
  - Be free of pain

## 7. Stress Habits – Check Which Apply:

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Is your job associated with potentially harmful chemicals, pesticides, radioactivity or solvents? Y  N

Do you suffer from insomnia/sleep disorders? Y  N

Do you often abruptly awake from sleep? Y  N

Do you suffer from depression/mood swings? Y  N

## 10. Longevity – Life Enrichment

- I'd like to:
- Reduce my risk of degenerative disease
  - Slow down accelerated aging
  - Monitor biomarkers of aging
  - Have less facial wrinkles
  - Maintain a healthier life longer
  - Change from a "treating-illness" orientation to a creating wellness lifestyle

## 8. Supplement Use Habits – Check Which Apply:

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- GLA (Evening primrose)
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (lutein, resveritol, etc.)
- Herbs – teas
- Herbs – extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Superfoods (bee pollen, phytonutrient blends)
- Liquid meals (Ensure)
- Other \_\_\_\_\_

## 11. Body Composition – Fat/Muscle

- I'd like to:
- Be stronger
  - Be thinner
  - Be more muscular
  - Burn more body fat
  - Be more flexible
  - Lose weight

## 12. Stress Reduction – Mental/Emotional

- I'd like to:
- Be happier
  - Be less depressed
  - Be less moody
  - Be less indecisive
  - Be more focused
  - Think more clearly
  - Improve my memory
  - Learn how to reduce stress
  - Learn how to meditate

## COMMENTS

Suzanne Peppell, N.D.  
1457 Hildenbrandt Road  
Wind Gap, PA 18091  
(610) 759-7001

**Informed Consent**

Name \_\_\_\_\_  
(please print)

1. This is to acknowledge that I have been informed and understand that:
  - a) Suzanne Peppell, N.D. is not a licensed health care provider, and does not diagnose or treat disease. Only licensed health care providers can diagnose and treat disease in Pennsylvania.
  - b) Any recommendations or advice provided to me as a client of Suzanne Peppell, N.D. is not mutually exclusive from any treatment or advice that I may be receiving now or in the future from any health care provider.
  - c) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider.
  - d) I understand that Suzanne Peppell, N.D. is not recommending that I refrain from seeking or following the advice of any licensed health care provider.
  - e) I understand that the recommendations provided might be different from those usually offered by licensed health care providers.
2. I agree to pay for consultations, supplements, and other services.
3. I understand that Suzanne Peppell, N.D. does NOT offer 24-hour, emergency care, and if I need emergency care I must call 911 or proceed to the nearest emergency room.
4. I have been given a copy of current office policies and understand that it is my responsibility to read these policies.
5. I have had my questions regarding this consent form and naturopathic medicine answered to my satisfaction.

Name (printed) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

## Office Policies for Clients

### Emergencies

- Suzanne does **NOT** offer 24-hour emergency care.
- Call 911 or proceed to the nearest emergency room if you are experiencing a medical emergency. **Any serious medical condition or emergency should be treated by an emergency room doctor.**

### Cancellation & No-Show Policy

- Please notify the office at least 24 hours in advance if you need to cancel or reschedule an appointment.
- Clients who fail to show or call 24 hours in advance to reschedule or cancel an appointment are billed \$20.00.

### Phone

- Calls from established clients for clarification on current plans are welcome. However, please keep calls to 5 minutes or less.
- If you have many questions, new health concerns, or you anticipate a lengthy phone call, please schedule an office appointment. Phone calls during office hours that are longer than 5 minutes are subject to a fee at the usual, office visit rate.

### Payment

- Payment is expected at the time of service.
- MasterCard, Visa, AMEX, and Discover are accepted, as well as personal checks.
- There is a \$20.00 charge for returned checks.

### Supplements

- Suzanne does not carry multi-level marketing products, or expect or demand that supplements be purchased through her. Local health food stores carry many homeopathic remedies, botanical medicines, and vitamin and mineral supplements.
- A limited selection of supplements are available because:
  - some clients are unable to find or chose appropriate supplements.
  - certain specialty products are unavailable locally.
  - clients with immediate health concerns need immediate access to supplements.
- If you need to reorder supplements, please notify the office at least **10 days** in advance of when you will need them.
- All supplement orders require prepayment.
- Special order and non-stock supplements are **non-returnable**.
- All other supplements are returnable within 7 business days as long as they are in the same condition as when sold (undamaged, unopened, unused).

*These policies are subject to change.  
Effective 01/2007.*