



FAMILY INTAKE
Health Questionnaire

OFFICE USE ONLY
Shareholder No.:
_____ | _____

Shareholder's Name:		Date:		
1. Have you had heart trouble or coronary disease? <input type="checkbox"/> yes <input type="checkbox"/> no	13. Are you taking anti-depressant medication? <input type="checkbox"/> yes <input type="checkbox"/> no			
2. Do you have a family history of heart problems or coronary heart disease? <input type="checkbox"/> yes <input type="checkbox"/> no	14. How many hours do you sleep at night? <input type="checkbox"/> -3 Hrs <input type="checkbox"/> 3-5 Hrs <input type="checkbox"/> 5-8 Hrs <input type="checkbox"/> 8 Hrs +			
3. Do you have a history of high blood pressure? <input type="checkbox"/> yes <input type="checkbox"/> no	15. Are you currently under the care of a physician? <input type="checkbox"/> yes <input type="checkbox"/> no			
4. Do you have Diabetes? <input type="checkbox"/> yes <input type="checkbox"/> no	16. Do you exercise regularly? <input type="checkbox"/> yes <input type="checkbox"/> no			
5. If yes, what type? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type II <input type="checkbox"/> Borderline	17. Do you have any body weight issues, that you would want to address? <input type="checkbox"/> yes <input type="checkbox"/> no			
6. Do you have high cholesterol? <input type="checkbox"/> yes <input type="checkbox"/> no	18. Do you smoke? <input type="checkbox"/> yes <input type="checkbox"/> no			
7. Do you have trouble sleeping? <input type="checkbox"/> yes <input type="checkbox"/> no	19. How many cups of coffee do you drink a day? <input type="checkbox"/> None <input type="checkbox"/> 1-2 cups <input type="checkbox"/> 3-5 cups <input type="checkbox"/> 6 cups +			
8. Do you have recurring headaches? <input type="checkbox"/> yes <input type="checkbox"/> no	20. Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no			
9. If yes, to question 8, how long do they last? _____ What do you take for pain relief? _____	21. Do you have any drug or food allergies or intolerances? <input type="checkbox"/> yes <input type="checkbox"/> no			
10. Do you have any anxiety or panic attacks? <input type="checkbox"/> yes <input type="checkbox"/> no	22. Please list any drug or food allergies/intolerances:			
11. Does your mind 'race'? <input type="checkbox"/> yes <input type="checkbox"/> no	23. What would you like to change about your health? <input type="checkbox"/> yes <input type="checkbox"/> no			
12. Do you feel like you are going 'crazy'? <input type="checkbox"/> yes <input type="checkbox"/> no	24. Are you taking any prescribed medication?			
25. Please list any and all prescribed medications you are taking:				
26. How much water do you drink a day? <input type="checkbox"/> None <input type="checkbox"/> 1-2 Glasses <input type="checkbox"/> 3-5 Glasses <input type="checkbox"/> 6-8 Glasses <input type="checkbox"/> 9 Glasses +				
27. Have you been treated for, diagnosed as having, or currently suffering from any of the following:				
a) Cancer	<input type="checkbox"/> N/A	<input type="checkbox"/> Treated	<input type="checkbox"/> Diagnosed	<input type="checkbox"/> Suffering
b) Any infectious progressive illness, such as Hepatitis B, Acquired Immune Deficiency Syndrome (AIDS) or other conditions?	<input type="checkbox"/> N/A	<input type="checkbox"/> Treated	<input type="checkbox"/> Diagnosed	<input type="checkbox"/> Suffering
c) Nervous or Mental disorder	<input type="checkbox"/> N/A	<input type="checkbox"/> Treated	<input type="checkbox"/> Diagnosed	<input type="checkbox"/> Suffering
d) Recurrent Headaches	<input type="checkbox"/> N/A	<input type="checkbox"/> Treated	<input type="checkbox"/> Diagnosed	<input type="checkbox"/> Suffering
e) Any sexually transmitted diseases (STD's)	<input type="checkbox"/> N/A	<input type="checkbox"/> Treated	<input type="checkbox"/> Diagnosed	<input type="checkbox"/> Suffering
d) Depression	<input type="checkbox"/> N/A	<input type="checkbox"/> Treated	<input type="checkbox"/> Diagnosed	<input type="checkbox"/> Suffering
e) Back or neck strain	<input type="checkbox"/> N/A	<input type="checkbox"/> Treated	<input type="checkbox"/> Diagnosed	<input type="checkbox"/> Suffering
f) Epilepsy	<input type="checkbox"/> N/A	<input type="checkbox"/> Treated	<input type="checkbox"/> Diagnosed	<input type="checkbox"/> Suffering
g) Obesity	<input type="checkbox"/> N/A	<input type="checkbox"/> Treated	<input type="checkbox"/> Diagnosed	<input type="checkbox"/> Suffering
h) Tuberculosis	<input type="checkbox"/> N/A	<input type="checkbox"/> Treated	<input type="checkbox"/> Diagnosed	<input type="checkbox"/> Suffering
i) Other: Please explain:	<input type="checkbox"/> N/A	<input type="checkbox"/> Treated	<input type="checkbox"/> Diagnosed	<input type="checkbox"/> Suffering

I certify that all the above information is true and correct to the best of my knowledge. I am aware that making any false statements can, and will affect KiiKeeWanNiiKaan's ability to meet my needs for the duration of my stay at the Lodge.

X _____
Shareholder Signature

Date

X _____
Witness Signature

Date

* Copy & complete this sheet for each **shareholder** stated on Form 1a.