Complexity Questionnaire

Name: _____ **Date:** _____

Emotional

Have you experienced panic or anxiety attacks?	Yes	No
Do you have any history of PTSD-Post Traumatic Stress Disorder?	Yes	No
Have you ever suffered from emotional or sexual abuse?	Yes	No
Do you have any addictive behaviors?	Yes	No
Have you struggled with an eating disorder?	Yes	No
Have you received professional counseling?	Yes	No
Do you participate in church regularly?	Yes	No

Female Only

Have you received breast implants?	Yes	No
Do you have a history of vaginal yeast infections?	Yes	No
Are you currently using birth control	Yes	No
If so, which types?	_____	

Mold Exposure

Have you ever lived in a basement?	Yes	No
Have you ever been exposed to any form of mold?	Yes	No

Oral

Have you ever had a root canal dental procedure?	Yes	No
Do you have mercury fillings in your teeth?	Yes	No
Do you have sensitivity in your teeth or gums to cold or hot water?	Yes	No

Other

Do you suffer from any ongoing sinus congestion or sinusitis?	Yes	No
Do you have any known thyroid problems?	Yes	No
Have you had Lyme disease or been bitten by a deer tick?	Yes	No
Exposed to hazardous waste, environmental toxins, chemicals, or pollutants?	Yes	No
Do you drink city water?	Yes	No
Do you drink well water?	Yes	No
Do you drink reverse osmosis water?	Yes	No
Do you drink energy drinks?	Yes	No
Do you drink coffee?	Yes	No
Do you have urinary tract infections?	Yes	No
Do you use perfume or cologne?	Yes	No
Average number of hours per day sitting?	_____	

Screen Usage

How many hours of time do you average per day on:	the phone:	_____
	social media:	_____
	computer (work or leisure):	_____
	television:	_____

Please see other side

Skin

Do you have scars? Yes No
Do you have tatoos? Yes No
Have you received botox injections for any reason? Yes No

Sleep

Do you sleep well? Yes No
Do you fall asleep quickly, within 5 - 10 minutes after the lights are out? Yes No
Do you sleep through the night without waking? Yes No
How many times per night do you wake up? _____
Have you ever been told that you snore? Yes No
Do you ever hold your breath at night while you are sleeping? Yes No
Have you ever been told that you have sleep apnea? Yes No
How many hours of sleep do you get on average per night? _____
Do you feel that you sleep poorly at night? Yes No

Substance Use

Do you smoke or chew tobacco? Yes No
If you previously smoked or chewed tobacco, how long? _____
Do you vape? Yes No
If you previously vaped, how long? _____
Do you use marijuana? Yes No
If you previously used marijuana, how long? _____
Do you use illegal drugs? Yes No
If you previously used illegal drugs, how long? _____
If drug use, which drugs did you use? _____

Vaccines

Have you received childhood vaccinations? Yes No
Have you received Covid-19 vaccinations? Yes No
Have you received flu vaccines? Yes No
Have you received boosters? Yes No

Other Medications/Autoimmunity

History of antibiotic use: _____ Last time used: _____
Are you on immunosuppresant drugs?
Are you on steroids?
Are you/or have you done chemotherapy?
Do you have a low white blood cell count (below 4,500)?
Have you been diagnosed with an autoimmune disease?
If yes, which autoimmune condition? _____
when diagnosed? _____
what are you doing to treat this condition? _____