

QUESTIONNAIRE FORM

Participant Information:

Full Name: _____

Date of Birth: _____

Gender: _____

Address: _____

Phone Number: _____

Email Address: _____

Section 1: Medical History

1. Do you have any allergies? (If yes, please specify)

2. Are you currently taking any medications? (If yes, please list)

3. Do you have any chronic illnesses or conditions? (If yes, please describe)

4. Have you had any surgeries in the past 5 years? (If yes, please provide details)

5. Do you have any history of heart disease, diabetes, or respiratory problems?

6. Are you pregnant or breastfeeding?

7. Do you suffer from epilepsy, seizures, or fainting spells?

8. Do you have any physical disabilities or limitations?

9. Have you had any recent hospitalizations?

10. Do you smoke or use tobacco products?

Section 2: Lifestyle and Habits

11. How often do you exercise per week? (Frequency and type)

12. Do you consume alcohol? (If yes, how often?)

13. Do you follow any specific diet or nutrition plan?

14. Do you use recreational drugs? (If yes, please specify)

15. How many hours of sleep do you get on average per night?

16. Do you have any stress management techniques you use regularly?

17. Have you experienced any significant life changes recently?

18. Do you have any concerns about your mental health?

19. Do you have a regular healthcare provider?

20. Are you up to date with your vaccinations?

Section 3: Consent and Acknowledgment

I hereby certify that the information provided above is true and correct to the best of my knowledge. I understand that providing false information may result in disqualification from participation. I consent to the use of this information for the purposes of evaluation and record keeping in accordance with applicable United States laws regarding privacy and data protection.

Participant's Signature:

Date:

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