Confidential Client Health Questionnaire

Consultation Date:_____ Consultation Time:_____

** All of your personal information will remain strictly confidential! **

Name:_____
E-mail Address:_____
Street Address:_____
City_____ State:_____ Zip:_____
Home Phone:_____ Work/Cell Phone:_____
Date of Birth:_____ Place of Birth:_____
Age:_____ Gender:_____ Height:_____ Current Weight:_____
Would you like your weight to be different?_____ If so, what?_____
Occupation:_____ How many hours do you work per weeks?_____
Relationship Status:_____ Children?_____
Blood Type (if known):_____ Referred by:_____
Hobbies/Activities:_____

What are your health concerns? _____
_____
_____
_____

What would you like to accomplish/gain from this consultation? _____
_____
_____

Do you sleep well?_____ Do wake up during the night?_____
If so, what time(s)?_____ What time do you go to bed?_____
What time do you generally wake-up?_____
How do you feel when you wake up? _____
Do you drink caffeinated drinks?_____ How much & how often?_____

Do you smoke?_____ How much & how often?_____
If no, why, how and when did you quit smoking?_____
Exposure to Secondhand Smoke?_____ If so, how and how long?_____
Do you drink alcohol?_____ How much & how often?_____
Do you drink soda (diet or regular)?_____ How much & how often?_____
How much water do you drink per day?_____
What role does exercise play in your life?_____
_____
Have you been exposed to toxic substances at work or home?_____
Do you have any allergies?_____
_____
_____

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/non-prescription medications, aspirin, laxatives, diet pills, or any other supplements? Please list all below including name brands and amounts:_____
_____
_____
_____

Do you have any known allergies to medications or herbs?_____ Please list all:_____
_____
_____
_____

Are you currently under a practitioner's care for a specific health issue?_____
If so, what treatments are you undergoing?_____
_____
_____

Please list any surgeries, accidents, injuries or childhood diseases you have had along with the type and date:_____
_____
_____
_____

Have you had and dental procedures done i.e. fillings, root canals, pulled teeth, crowns, etc.?

_____

_____

What were your eating habits like as a child? (List types of foods)_____

_____

_____

What percentage of your food is home cooked?_____
How often do you eat out?_____
What are the three worst foods you eat each week?_____

_____

What are the three healthiest foods you eat each week?_____

_____

What is one food you'd be reluctant to give up?_____
Do you crave sugar?_____ Do you crave salt?_____
Do you feel tired, bloated, and/or gassy after meals?_____
Do you experience constipation or diarrhea often?_____
When & how often?_____
Do you ever notice undigested food in your stools? If so, how often?_____

_____

Do you feel excessively hungry?_____ Do you have a poor appetite?_____

Family Health History (Indicate "Yes" with a check mark)

Arthritis		Asthma		Diabetes	
Gallbladder Disease		Heart Disease		Kidney Disease	

Cancer		Type of Cancer	
Stomach/Intestinal Issues		Other (List)	

Mother age:		Died from:	
Father age:		Died from:	
Maternal Grandmother age:		Died from:	
Maternal Grandfather		Died from:	

age:			
Paternal Grandmother age:		Died from:	
Paternal Grandfather age:		Died from:	

Women Only

Age of your first period:_____ Are your periods regular?_____
How frequent?_____ Any pregnancies? How many?_____
How many days is your flow?_____
Do you experience PMS?_____ Is it mild or severe?_____
Are you peri-menopausal?_____ When did this change first occur?_____
Are you menopausal?_____ When was your last period?_____
List your symptoms of peri/menopause:_____
_____
_____
How many children have you delivered and how were they born (vaginally or by cesarean)?____
_____
Were there complications associated with these births?_____
Please explain:_____
_____
Did you receive antibiotics during labor?_____
Have you ever had a miscarriage or an abortion?_____ How many?_____

Men Only

Approximate age of onset of puberty:_____ Any children?_____
Do you feel your libido is adequate? Y N Comments:_____
Do you wake at night to urinate?_____ How many times per night?_____
Do you have any difficulty and/or pain with urination? Y N
Diminished volume or flow? Y N
Do you enjoy daily activities? Y N
Do you feel apathetic or complacent about previously enjoyed sports, hobbies, clubs, games, etc.?_____
_____
Do you notices feeling more agitated/irritable than previously?_____
Do you feel less assertive in daily life than previously?_____
Would you like to discuss men's health issues specifically?_____

Food Journal - Day 1

NAME:_____DATE:_____

Write down everything you eat or drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it in the right-hand column.

MEAL	BEVERAGES	Mood/Digestive Changes
Breakfast (Time:_____)		
Snack (Time:_____)		
Lunch (Time:_____)		
Snack (Time:_____)		
Dinner (Time:_____)		
Snack (Time:_____)		

Food Journal - Day 2

NAME:_____DATE:_____

Write down everything you eat or drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it in the right-hand column.

MEAL	BEVERAGES	Mood/Digestive Changes
Breakfast (Time:_____)		
Snack (Time:_____)		
Lunch (Time:_____)		
Snack (Time:_____)		
Dinner (Time:_____)		
Snack (Time:_____)		

Food Journal - Day 3

NAME:_____DATE:_____

Write down everything you eat or drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it in the right-hand column.

MEAL	BEVERAGES	Mood/Digestive Changes
Breakfast (Time:_____)		
Snack (Time:_____)		
Lunch (Time:_____)		
Snack (Time:_____)		
Dinner (Time:_____)		
Snack (Time:_____)		