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Confidential Client Health Questionnaire

Please take a few minutes to answer the following questionnaire. There are many areas of health that can be improved/changes with nutrition. Please answer all the questions you feel comfortable answering. All of your personal information will remain strictly confidential.

NAME: _____

EMAIL ADDRESS: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PREFERED PHONE: _____ (HOME/WORK/CELL)

PREFERED FORM OF COMMUNICATION (please circle one): EMAIL/CALL/TEXT

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

AGE: _____ GENDER: _____ HEIGHT: _____ WEIGHT: _____

Would you like your weight to be different? _____ If yes, what? _____

OCCUPATION: _____

How many hours do you work per week? _____

RELATIONSHIP STATUS: _____ # of 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? _____ What time do you go to bed? _____

What time do you generally wake up in the morning? _____

How do you generally feel when you wake up in the morning? _____

Do you wake up in the middle of the night? _____ If so, what time?_____

Do you drink caffeinated drinks? _____ How much & how often? _____

Do you smoke? _____ How much & how often? _____

Did you suffer from second hand smoke as a child? _____

Do you drink alcohol? _____ How much & how often? _____

Do you drink soda? _____ How much & how often? _____

Do you exercise regularly? _____ How much & how often? _____

Have you been exposed to toxic substances at work or home? _____

How much water do you drink daily? _____

Do you have any known allergies? _____

_____

_____

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

_____

_____

_____

_____

Are you currently under a practitioner's care for a specific health issue? _____

If yes, what treatments are you undergoing? _____

_____

_____

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

_____

_____

What were your eating habits like as a child (please list types of foods)?

_____

_____

_____

What percentage of your food is home cooked? _____

How often do you eat out? _____

What are the 3 worst foods you eat each week? _____

_____

What are the 3 healthiest foods you eat each week? _____

_____

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

MEN ONLY:

Approximate age of onset puberty: _____

Do you feel your libido is adequate? YES or NO Comments? _____

_____

Do you wake at night to urinate? _____ How many times per night? _____

Do you have difficulty and/or pain with urination? YES OR NO

Do you have diminished volume or flow? YES OR NO

Do you enjoy daily activities? YES OR NO

Do you feel apathetic or complacent about previously enjoyed sports, hobbies, clubs, games, etc? _____

Do you notice feeling more agitated/irritable than previous? _____

Do you feel less assertive in daily life than previously? _____

Would you like to discuss men's health issues specifically? YES OR NO

WOMEN ONLY:

Age of your first period: _____ Are your periods regular? _____

How frequent? _____ # of pregnancies: _____

How many days if 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? _____

PleDid you receive antibiotics during labor? _____

Have you ever had a miscarriage or an abortion? _____ How many? _____

FAMILY HISTORY (indicate with a check mark):

Diabetes:		Kidney Disease:		Asthma:	
Heart Disease:		Arthritis:		Gallbladder Disease:	

Cancer		Type of cancer?	

Mother (age):		Died from:	
Father (age):		Died from:	
Maternal Grandmother:		Died from:	
Paternal Grandmother:		Died from:	
Maternal Grandfather:		Died from:	
Paternal Grandfather:		Died from:	

NUTRITIONAL THERAPY INFORMED CONSENT AND DISCLAIMER

Before you choose to use the serviced of a certified nutritional therapy practitioner, please read the following information FULLY AND CAREFULLY.

GOAL: Our basic goal is to encourage people to become knowledgeable about and responsible for their own health, and to bring it to a personal optimum level. Nutritional therapy is designed to improve your health, but is not designed to treat any specific disease or medical condition. Reaching the goal of optimum health, absent other non-nutritional complicating factors, requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. A Nutritional Therapist is trained to evaluate your nutritional needs and make recommendations of dietary change and nutritional supplements. A Nutritional Therapist is not trained to provide medical diagnoses, and no comment or recommendation should be construed as being a medical diagnosis. Since every human being is unique, we cannot guarantee any specific result from our programs.

HEALTH CONCERNS: If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider. A Nutritional Therapist is not a substitute for your family physician or other appropriate healthcare provider. A Nutritional Therapist is not trained nor licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases.

If you are under the care of another healthcare provider, it is important that you contact your other healthcare provider and alert them to your use of nutritional supplements. Nutritional therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important you always keep your physician informed of changes in your nutritional program. If you are using medications of any kind, you are required to alert me, your nutritional therapist, to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist.

If you have any physical or emotional reaction to nutritional therapy, discontinue their use immediately, and contact me, your nutritional therapist, to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the therapy.

COMMUNICATION: Every client is an individual. And it is not possible to determine in advance how your system will react to the supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct the imbalance. It is your responsibility to do your part by using your nutrition guidelines, exercise your body and mind sufficiently to bring your emotions into a positive balance, eat a proper diet, get plenty of rest, and learn about nutrition. You must stay in contact with me, your nutritional therapist, so I can let you know what is happening and the best course of action.

You should request your other healthcare provider, if any, to feel free to contact me for answers to any questions they may have regarding nutritionally therapy.

LICENSURE: A Nutritional Therapist is not a licensed profession by any state. However, a certified Nutritional Therapy Practitioner is trained by the Nutritional Therapy Association, Inc. ® which provides a certification of completion to students who have successfully met all course requirements, including a written and practical examination. A license to practice Nutritional Therapy is not required in the state of California.

Nutritional Therapy may not be covered by insurance and all costs are the responsibility of the client.

By my signature below, I confirm that I have read and fully understand the above declaimer, are in complete agreement thereto and do freely and without duress sign and consent to all terms contained herein.

NAME (PLEASE PRINT): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE (HOME): _____ CELL: _____

SIGNATURE: _____ DATE: _____

SIGNATURE FOR CLIENT: _____

RELATIONSHIP TO CLIENT: _____ DATE: _____