

NEW CLIENT QUESTIONAIRE

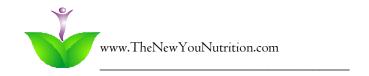
Date				
Name				
Phone - H	Email			
C				
W				
Address				
Date of Birth	Age	Gender	Ethnicity	
Height Weight				
Marital Status				
Reason for your visit				
Who referred you?				
Occupation	Hours of	work per week		<u> </u>
Work environment (check all that apply)	:			
\square Sitting \square Mixture sitting/walking	☐ Computer ☐ I	Lifting/carrying		
\square Driving \square Outside \square Inside/fluc	orescent lights 🗌 I	nside/natural light		
☐ Other				
Circle one:				
Stress level - High/Medium/Low				
Satisfaction - High/Medium/Low				
What do you like to do in your free time	?			



Personal Health and Habit	ts:		
How would you describe y	our health in general? _		
List your primary health co	omplaints/symptoms? _		
	• •	edications, herbs, and vitamins. Include dosage, reason for	_
Do you:			
Smoke tobacco?	How much?		
Drink alcohol?	How often?		
Use recreational drugs?	What kind and ho	ow often?	
How often do you have a b	oowel movement?		
Any problems with your bo	owel movements?		
		What time do you get up?	
		How do you feel when you get up?	
List regular physical activit	ies (type, duration and	frequency):	



Current Health	care Practiti	oners:		
Name	Tit	tle Ph	one	Reason for seeing him/her
Surgeries				
Hospitalization	s			
Significant or c	hronic health	n issues in past		
Ü		,		
How often do y	ou get sick?			
Family Health	History:			
	Age	Living (Y/N)		Health Issues
Faller	Age	Living (1/14)		rieditii issues
Father				
Mother				
Siblings				
Grandparents				

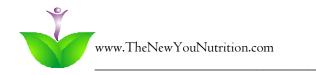


Eating patterns:

On average, how many times a week do you:					
Cook meals at home? Eat at a restaurant? Eat breakfast? Shop for food?					
Do you enjoy cooking?					
Number of meals per day Do you snack/how often?					
Eat in the car? Eat and work simultaneously?					
How much water do you consume a day? What kind (tap, filtered, etc)?					
Do you drink coffee? How much per day?					
Do you drink sodas? How many per day?					
Do you have food cravings? What types of foods?					
Favorite foods					
Least favorite foods					
Where do you usually shop for food?					
Do you have food allergies? Please list Any dietary restrictions?					
Any significant weight loss/gain in the past 6 months?					
Have you ever had an eating disorder?					
Eating Patterns (check all that apply):					
\square Emotional Eater \square Forget to Eat \square Hungry all the time \square Eat out of boredom					
\square Eat out of necessity $\ \square$ No appetite $\ \square$ Don't know when to stop					
☐ Other					
l eat:					
☐ Too Much ☐ Just enough ☐ Not enough					
Any non-food allergies? Please list					



Health Goals:
What are your goals and vision for your health going forward?
On a scale of 1-10 (10 being very motivated), how motivated are you to change diet/eating habits?
Do you have a time frame for achieving these goals? What is it?
Does your lifestyle support your goals?
What type of support system do you have to change your diet/nutrition/habits?
What obstacles do you have to make a change in your diet/nutrition/habits?
Is there anything else you would like to discuss?



Symptom Review:

Please check the box if you experience any of the following. Where appropriate on checked boxes, please indicate one of the following: **1** = **infrequent**, **2** = **often**, **3** = **always**

Head -	Neck-	Urinary-
☐ Headache	Lumps	☐ Frequency
☐ Migraine	Swollen glands	□ Urgency
□ Dandruff	☐ Pain/stiffness	☐ Burning or pain w/ urination
☐ Head injury	Tension /limited movement	☐ Blood in urine
☐ Oily/Dry hair		☐ Incontinence
☐ Hair loss	Mouth/Throat-	☐ Tract infections (UTI)
Eyes-	☐ Bleeding gums	☐ Kidney stones
☐ Vision Loss/changes	☐ Dry mouth	
□ Dry/watery	☐ Sore throat/hoarseness	Gastrointestinal-
□ Redness	☐ Thrush	☐ Swallowing difficulties
☐ Itchy	□ Non-healing sores	☐ Heartburn
☐ Blurry or double vision	Canker sores	☐ Change in appetite
☐ Flashing lights	Cold sores	□ Nausea
Glaucoma	Cavities	☐ Indigestion/bloating
Cataracts	☐ Loss of taste	☐ Recent change in BM
☐ Dark under eyes	Skin-	☐ Rectal bleeding
□ Styes	☐ Rashes/hives	☐ Constipation
	☐ Lumps	☐ Diarrhea
☐ Discharge	☐ Itching	☐ Yellow eyes or skin
	☐ Psoriasis/eczema	□ Vomiting
Nose-	□ Dryness	Hemorrhoids
☐ Stuffiness	☐ Cancer	☐ Pancreatitis
Discharge	□ Warts/moles	□ Ulcer
Frequent colds	☐ Easy bruising	☐ Gall bladder disease
Post nasal drip	☐ Easy bleeding	☐ Floating stools
Seasonal allergies	Nails -	☐ Excessive gas
☐ Sinus pain	☐ Fungal fingernails/toenails	Respiratory-
Ears-	☐ Ridging	□ Cough
☐ Decreased hearing	☐ White spots	☐ Coughing up blood/mucus
☐ Ringing in ears	☐ Brittle/dry	☐ Shortness of breath
☐ Earache	□ Peeling	☐ Wheezing
☐ Drainage		☐ Painful breathing
	Endocrine-	☐ Bronchitis
	☐ Heat or cold intolerance	□ Pneumonia
	☐ Sweating	☐ Asthma
	☐ Thirst	



Cardiovascular-	Sleep/Energy	For Females -
☐ Chest pain or discomfort	☐ Trouble sleeping	☐ Heavy menstrual bleeding
☐ Tightness	☐ Waking at night	☐ Menstrual cramping/pain
☐ Palpitations	☐ Fall asleep easily	□ PMS
☐ Shortness of breath	☐ Unrefreshed after waking	Age period began:
☐ Difficulty breathing	□ Nap	How often period occurs:
☐ Swelling	☐ Sleepy in the afternoon	How long period lasts:
☐ High/low blood pressure	□ Fatigue	Use (d) hormonal birth control
☐ Murmurs	Toxicity	□ Pregnancy
☐ Arrhythmias	☐ Live(d) near farm, refinery or a	How many:
Musculoskeletal-	polluted area	☐ Miscarriages
☐ Muscle or joint pain	☐ Solvent use in work or hobbies	☐ Abortions
□ Stiffness		□ STD
Back pain	Live(d) in house with leaded paint	☐ Menopausal
☐ Redness of joints	(built before 1976)	Since what age:
☐ Swelling of joints	☐ Health problem after home	☐ Use (d) hormone
☐ Trauma	refurbishing	replacement:
☐ Arthritis	☐ Medication sensitivities	□ Low libido
Leg cramps	☐ Sensitive to smells	☐ Vaginal dryness
☐ Tremors	☐ Use pesticides, herbicides, or other	☐ Recurring vaginal yeast infections
□ Paralysis	chemicals	
☐ Carpal tunnel syndrome	☐ Mercury fillings	☐ Pain w/ intercourse
	How many:	☐ Abnormal mammogram
Neurologic-	For Males -	Last mammogram:
☐ Dizziness	☐ Testicular pain/swelling	☐ Abnormal pap
Fainting	☐ Hernia	Last pap smear:
☐ Seizures	□ STD	
☐ Weakness	☐ Discharge	
□ Numbness	☐ Prostate disease	
☐ Tingling	☐ Difficulty w/ urination	
☐ Tremor	☐ Impotency	
Mental/Emotional -	impotency	
☐ Depression		
☐ Anger/irritability		
☐ Suicidal		
☐ Anxiety		
☐ Fear/panic		
□ Nervousness		
□ Stress		
☐ Memory loss		