The New You Nutrition

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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 _____

Work environment (check all that apply):

☐ Sitting ☐ Mixture sitting/walking ☐ Computer ☐ Lifting/carrying

☐ Driving ☐ Outside ☐ Inside/fluorescent lights ☐ Inside/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 Habits:

How would you describe your health in general? _____

_____

List your primary health complaints/symptoms? _____

_____

_____

_____

_____

Medications and Supplements. List all types of medications, herbs, and vitamins. Include dosage, reason for taking and how often? _____

_____

_____

_____

Do you:

Smoke tobacco? _____ How much? _____

Drink alcohol? _____ How often? _____

Use recreational drugs? _____ What kind and how often? _____

How often do you have a bowel movement? _____

Any problems with your bowel movements? _____

What time do you usually go to bed? _____ What time do you get up?_____

How well do you sleep? _____ How do you feel when you get up? _____

List regular physical activities (type, duration and frequency):

_____

_____

Current Healthcare Practitioners:			
Name	Title	Phone	Reason for seeing him/her

Surgeries_____

Hospitalizations _____

Significant or chronic health issues in past _____

_____

_____

How often do you get sick? _____

Family Health History:			
	Age	Living (Y/N)	Health 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):

☐ Emotional Eater ☐ Forget to Eat ☐ Hungry all the time ☐ Eat out of boredom

☐ Eat out of necessity ☐ No appetite ☐ Don't know when to stop

☐ Other _____

I 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 -
- ☐ Headache _____
- ☐ Migraine _____
- ☐ Dandruff _____
- ☐ Head injury _____
- ☐ Oily/Dry hair _____
- ☐ Hair loss _____

Eyes-
- ☐ Vision Loss/changes _____
- ☐ Dry/watery _____
- ☐ Redness _____
- ☐ Itchy_____
- ☐ Blurry or double vision _____
- ☐ Flashing lights _____
- ☐ Glaucoma _____
- ☐ Cataracts _____
- ☐ Dark under eyes
- ☐ Styes _____
- ☐ Strain_____
- ☐ Discharge _____

Nose-
- ☐ Stuffiness _____
- ☐ Discharge _____
- ☐ Frequent colds_____
- ☐ Post nasal drip_____
- ☐ Seasonal allergies _____
- ☐ Sinus pain _____

Ears-
- ☐ Decreased hearing _____
- ☐ Ringing in ears _____
- ☐ Earache _____
- ☐ Drainage _____

Neck-
- ☐ Lumps _____
- ☐ Swollen glands _____
- ☐ Pain/stiffness _____
- ☐ Tension /limited movement _____

Mouth/Throat-
- ☐ Bleeding gums _____
- ☐ Dry mouth _____
- ☐ Sore throat/hoarseness _____
- ☐ Thrush _____
- ☐ Non-healing sores _____
- ☐ Canker sores _____
- ☐ Cold sores _____
- ☐ Cavities _____
- ☐ Loss of taste _____

Skin-
- ☐ Rashes/hives _____
- ☐ Lumps _____
- ☐ Itching _____
- ☐ Psoriasis/eczema _____
- ☐ Dryness _____
- ☐ Cancer _____
- ☐ Warts/moles _____
- ☐ Easy bruising _____
- ☐ Easy bleeding _____

Nails -
- ☐ Fungal fingernails/toenails _____
- ☐ Ridging _____
- ☐ White spots _____
- ☐ Brittle/dry _____
- ☐ Peeling _____

Endocrine-
- ☐ Heat or cold intolerance _____
- ☐ Sweating _____
- ☐ Thirst _____

Urinary-
- ☐ Frequency _____
- ☐ Urgency _____
- ☐ Burning or pain w/ urination _____
- ☐ Blood in urine _____
- ☐ Incontinence _____
- ☐ Tract infections (UTI) _____
- ☐ Kidney stones _____

Gastrointestinal-
- ☐ Swallowing difficulties _____
- ☐ Heartburn _____
- ☐ Change in appetite _____
- ☐ Nausea _____
- ☐ Indigestion/bloating _____
- ☐ Recent change in BM _____
- ☐ Rectal bleeding _____
- ☐ Constipation _____
- ☐ Diarrhea _____
- ☐ Yellow eyes or skin _____
- ☐ Vomiting _____
- ☐ Hemorrhoids _____
- ☐ Pancreatitis _____
- ☐ Ulcer _____
- ☐ Gall bladder disease _____
- ☐ Floating stools _____
- ☐ Excessive gas _____

Respiratory-
- ☐ Cough _____
- ☐ Coughing up blood/mucus _____
- ☐ Shortness of breath _____
- ☐ Wheezing _____
- ☐ Painful breathing _____
- ☐ Bronchitis _____
- ☐ Pneumonia _____
- ☐ Asthma _____

Cardiovascular-

- ☐ Chest pain or discomfort _____
- ☐ Tightness _____
- ☐ Palpitations _____
- ☐ Shortness of breath_____
- ☐ Difficulty breathing _____
- ☐ Swelling _____
- ☐ High/low blood pressure _____
- ☐ Murmurs _____
- ☐ Arrhythmias _____

Musculoskeletal-

- ☐ Muscle or joint pain _____
- ☐ Stiffness _____
- ☐ Back pain _____
- ☐ Redness of joints _____
- ☐ Swelling of joints _____
- ☐ Trauma _____
- ☐ Arthritis _____
- ☐ Leg cramps _____
- ☐ Tremors _____
- ☐ Paralysis _____
- ☐ Carpal tunnel syndrome _____

Neurologic-

- ☐ Dizziness _____
- ☐ Fainting _____
- ☐ Seizures _____
- ☐ Weakness _____
- ☐ Numbness _____
- ☐ Tingling _____
- ☐ Tremor _____

Mental/Emotional -

- ☐ Depression _____
- ☐ Anger/irritability _____
- ☐ Suicidal _____
- ☐ Anxiety _____
- ☐ Fear/panic _____
- ☐ Nervousness _____
- ☐ Stress _____
- ☐ Memory loss _____

Sleep/Energy

- ☐ Trouble sleeping _____
- ☐ Waking at night _____
- ☐ Fall asleep easily _____
- ☐ Unrefreshed after waking _____
- ☐ Nap _____
- ☐ Sleepy in the afternoon _____
- ☐ Fatigue _____

Toxicity

- ☐ Live(d) near farm, refinery or a polluted area _____
- ☐ Solvent use in work or hobbies _____
- ☐ Live(d) in house with leaded paint (built before 1976) _____
- ☐ Health problem after home refurbishing _____
- ☐ Medication sensitivities _____
- ☐ Sensitive to smells _____
- ☐ Use pesticides, herbicides, or other chemicals _____
- ☐ Mercury fillings _____
  - ▪ How many: _____

For Males -

- ☐ Testicular pain/swelling _____
- ☐ Hernia _____
- ☐ STD_____
- ☐ Discharge _____
- ☐ Prostate disease _____
- ☐ Difficulty w/ urination _____
- ☐ Impotency _____

For Females -

- ☐ Heavy menstrual bleeding _____
- ☐ Menstrual cramping/pain _____
- ☐ PMS _____
  - ▪ Age period began: _____
  - ▪ How often period occurs:_____
  - ▪ How long period lasts: _____
- ☐ Use (d) hormonal birth control ___
- ☐ Pregnancy
  - ▪ How many: _____
- ☐ Miscarriages _____
- ☐ Abortions _____
- ☐ STD _____
- ☐ Menopausal _____
  - ▪ Since what age:_____
- ☐ Use (d) hormone replacement:_____
- ☐ Low libido _____
- ☐ Vaginal dryness_____
- ☐ Recurring vaginal yeast infections _____
- ☐ Pain w/ intercourse _____
- ☐ Abnormal mammogram _____
  - ▪ Last mammogram: _____
- ☐ Abnormal pap _____
  - ▪ Last pap smear: _____