Initial Interview: 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 week? _____

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? _____

What role does exercise play in your life? _____

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

_____

How much water do you drink per day? _____

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, 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, childhood diseases, or traumas 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? _____

_____

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? _____

Family Health History (Indicate Yes with a check mark)

Diabetes		Kidney disease		Asthma	
Heart Disease		Arthritis		Gallbladder disease	

Cancer		Type of cancer	
Stomach/Intestinal disorders		Other:	

Mother: Age:		Died from	
Father: Age:		Died from	

Maternal Grandmother: Age		Died from	
Paternal Grandmother: Age		Died from	

Maternal Grandfather: Age:		Died from	
Paternal Grandfather: Age		Died from	

WOMEN ONLY

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

How frequent? _____ Number of pregnancies: _____

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? _____ If yes, 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: _____ Number of children: _____

Do you feel your libido is adequate?: Y N Comments: _____

_____

Do you wake at night to urinate?: Y N 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? _____

_____

_____

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