CONFIDENTIAL HEALTH ASSESSMENT QUESTIONNAIRE

Please fill out the information that you feel comfortable sharing and what you think I need to know. If there is anything that makes you feel uncomfortable or you do not want to share, it is ok to leave it blank.

Contact Information

Name: _____Date: _____

E-mail Address:_____

Street Address:_____

Mailing Address (if different): _____

City:_____ State:_____Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____

Is this your first nutritional consultation? If not, please explain your past experiences:

_____

_____

_____

_____

Background

Age: _____ Gender:_____ Height:_____ Current Weight: _____

Occupation: _____

How many hours do you work per week?_____

Children?_____

Hobbies/Activities:_____

_____

_____

Please list your health concerns:

1._____

2._____

3._____

4._____

5._____

Please list your current health goals that you'd like to address:

1._____

2._____

3._____

4._____

5._____

Sleep

Do you sleep well? _____

Do you wake in the night? If so what time and why do you wake up (i.e. to urinate, bad dreams, hot flashes, etc) _____

How do you feel when you wake up? (restful, sick, tired, etc) _____

Daily Eating Habits

Please circle any of the symptoms below if it something that you experience often:

Bloating Heartburn Indigestion Gas Acid Reflux Constipation Diarrhea

What percentage of your food is home cooked?_____

Do you like to cook?_____

How often do you eat out?_____

How many meals do you eat per day? _____

Do you feel tired, bloated, and/or gassy after meals? _____

Do you drink caffeinated drinks, how much/how often?_____

Do you drink soda (diet or regular)? _____

How much water do you drink per day? _____

Do you eat meat? _____

Are you a vegetarian, vegan, plant-based, or do you follow another type of dietary lifestyle?

_____

Do you have any food allergies or sensitivities, such as dairy or gluten intolerance? If so, please explain_____

How many bowel movements do you have per day? _____per week?_____

Do you smoke? _____ If so, how much & how often? _____

Do you drink alcohol? _____ If so, how much and how often?_____

Health History:

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/nonprescription medications, aspirin, laxatives, diet pills, or any other supplements? Please list all below

_____

_____

Do you have any known allergies (medications, herbs, foods, etc)? Please list all:

_____

_____

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

_____

Is there anything that I need to know or that you would like me to know about your health history?

_____

_____

_____

_____

Movement and Relaxation:

Do you enjoy sports or activities? _____

What types of movement do you enjoy? _____

_____

How often? (days per week; hours per day)_____

What is the role exercise plays in your life? (ex: stress relief, weight management)

_____

On average, what would you rate your daily stress level (circle one)? 1=low and 10=high

1 2 3 4 5 6 7 8 9 10