NOURISH
holistic health & nutrition

**Nourish Holistic Health & Nutrition**

# Initial Interview

*Please fill out this form prior to your first appointment so we can get to know you and understand your health background.*

## Personal Information

Legal first name

Last name

Street

Unit

City

State/Province

Postal Code

Home Phone

Mobile Phone

Email Address

Date of Birth

Referred By

**Place of Birth:**

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

## Background:



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**Age:**

**Gender:**

**Height:**

Please enter your height in total inches.

**Current Weight:**

**How long have you been at your current weight?**

**Occupation:**

**How many hours do you work per week?**

**Relationship Status:**

**Children?**

**Blood Type (if known):**

**Hobbies/Activities**

## Goals:

**Please list your health concerns, as well as your health goals you'd like to address:**

At least 3 Goals



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## Sleep:

**What time do you typically go to sleep?**

**Do you sleep well?** ◯ Yes ◯ No

**What time do you typically wake up in the morning?**

**Do you remember your dreams?** ◯ Yes ◯ No

**Do you wake in the night? If so, what time and why do you wake up?**

Example: To urinate, bad dreams, hot flashes, etc.

**How do you feel when you wake up?**

Example: Restful, sick, tired, etc.

## Daily Eating Habits

**Please check any of the symptoms below if you have experienced them:**

- ☐ Bloating
- ☐ Indigestion
- ☐ Acid Reflux
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Gas
- ☐ Constipation

**Please describe the frequency of any of the symptoms you have checked and the intensity:**

**What were your eating habits like as a child?**

List the types of food you ate.

**What percentage of your food is home cooked?**

**How often do you eat out?**

**What type of cookware do you use?**

Example: Cast iron, aluminum, etc.

**What types of fats do you typically cook with?**

Example: Olive oil, butter, ghee, coconut oil, etc.

| | | |
|---|---|---|
| **Do you crave sugar?** | ◯ Yes | ◯ No |
| **Do you crave salt?** | ◯ Yes | ◯ No |
| **Do you feel tired, bloated, and/or gassy after meals?** | ◯ Yes | ◯ No |
| **Do you feel excessively hungry?** | ◯ Yes | ◯ No |
| **Do you have a poor appetite?** | ◯ Yes | ◯ No |
| **Do you drink caffeinated beverages?** | ◯ Yes | ◯ No |

**If so, how much/how often?**

**How much water do you drink per day?**

In fluid ounces.

**How many bowel movements do you have per day?**

**How many bowel movements do you have per week?**

**Do they sink or float?**

**Do you tend to have foul smelling gas?** ◯ Yes ◯ No

## Toxin Exposure:

**Do you smoke?** ◯ Yes ◯ No

**If so, how much/how often?**

**Are you exposed to secondhand smoke?** ◯ Yes ◯ No

**If so, how much/how long?**

**Do you drink alcohol?** ◯ Yes ◯ No

**If so, how much/how often?**

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

Example: Mold, cleaning supplies, heavy metals, etc.

**Do you have any amalgam fillings?** ◯ Yes ◯ No

**If so, have they been replaced or removed?**

## Health History:

## Please list any and all medications you are currently taking, as well as why you are taking them.

Product Name

Start Date

End Date

Quantity

Form

Route

Frequency

Additional Notes

## Please list any and all vitamins/minerals/herbs/homeopathic remedies, aspirin, laxatives, diet pills, or any other supplements you are currently taking and why you are taking them.

Product Name

Start Date

End Date

Serving

Unit

Frequency

Time of Day

Additional Notes

**Do you have any known allergies to medications, herbs, foods, etc?**

Please list all:

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

◯ Yes ◯ No

**If so, what treatments are you undergoing?**

**Please briefly describe your medical history (surgeries, accidents, diseases, dental procedures) both routine and significant. If possible, provide dates. Please list any surgeries, accidents, injuries, or childhood diseases you have had along with the type and date.**

**Do you have siblings?** ◯ Yes ◯ No

**If so, what order are you?**

First born, middle child, etc.

**Were you born vaginally or by cesarean?**

- ☐ Vaginally
- ☐ Cesarean
- ☐ Don't know

**Were you full-term, pre-mature, or late?**

- ☐ Full-term
- ☐ Pre-mature
- ☐ Late
- ☐ Don't know

**Were you breast fed?**

- ☐ Yes
- ☐ No
- ☐ Don't know

**If yes, until when?**

**If no, were you formula fed?**

## Movement and Relaxation:

**Do you enjoy sports or activities?** ◯ Yes ◯ No

**What types of movement do you enjoy?**

**How often?**

Days per week, hours per day.

**What is the role exercise plays in your life?**

Example: Stress relief, weight management.

**Do you have a history of over-exercising?** ◯ Yes ◯ No

**Do you feel you have a positive relationship with movement and exercise?** ◯ Yes ◯ No

**On average, how many hours a week are you sitting?**

**On average, what is your daily screen time?**

Phone, tablet, TV.

**On average, how many days a week do you meditate?**

**On average, what would you rate your daily stress level?**

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

*1 = Low, 10 = High*

## Family Health History:

**Check if you have/have had a family member with any of the following diseases:**

- ☐ Diabetes
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Gallbladder Disease
- ☐ Other:
- ☐ Heart Disease
- ☐ Stomach/Intestinal Disorders
- ☐ Arthritis
- ☐ Asthma:
- ☐ None

**If you checked yes for any of the above, please state what family member of yours had which disease.**

**If you checked yes for cancer, please specify the type.**

**If you checked for other, please specify.**

**Please share ages and causes of death for family members.**

| Family Member: | Age: | Died From: |
|---|---|---|
| **Mother** | | |
| **Father** | | |
| **Maternal Grandmother** | | |
| **Maternal Grandfather** | | |
| **Paternal Grandmother** | | |
| **Paternal Grandfather** | | |

## Additional Questions:

**Do you have light headedness when you bend over or stand up?** ◯ Yes ◯ No

**Do you ever have any ringing in your ears?** ◯ Yes ◯ No

**Do you ever experience any dull/achy low back pain?** ◯ Yes ◯ No

**Do you have any sensitivity to light and sound?** ◯ Yes ◯ No

Example: Always feeling like you have to wear sunglasses.

**Have you experienced any previous trauma?** ◯ Yes ◯ No

## Women Only:

**Age of your first period:**

**Are your periods currently regular?** ◯ Yes ◯ No

**Were they regular when they first started?** ◯ Yes ◯ No

**How frequent are your periods on average?**

**How many days in your flow?**

**How many days is your full cycle?**

**Are you currently on any form of birth control?** ◯ Yes ◯ No

For example, any variation of an IUD, birth control pill, implant, Depo Shot, etc.

**Have you ever been on any form of birth control?** ◯ Yes ◯ No

For example, any variation of an IUD, birth control pill, implant, Depo Shot, etc.

**Please check which best matches your monthly flow:**

☐ Light ☐ Medium

☐ Heavy

**Number of Pregnancies:**

**Do you experience PMS?** ◯ Yes ◯ No

**Is your PMS mild or severe?**

◯ Mild

◯ Severe

**Are you on any form of birth control?**

Pill, IUD, etc.

**Are you peri-menopausal?** ◯ Yes ◯ No

**When did this change first start?**

**Are you menopausal?** ◯ Yes ◯ No

**List your symptoms of peri/menopause:**

**How many children have you delivered and how were they born? (Vaginally or cesarean)**

**Were there complications with these births?** ◯ Yes ◯ No

**If yes, please explain:**

**Did you receive antibiotics during labor?** ◯ Yes ◯ No

**Are you currently pregnant or looking to become pregnant?** ◯ Yes ◯ No

**Are you currently having or have you ever had issues with fertility?** ◯ Yes ◯ No

**Have you ever had a miscarriage or an abortion?** ◯ Yes ◯ No

**If yes, how many?**

**Do you feel your libido is adequate?** ◯ Yes ◯ No

## Men Only:

**Approximate onset age of puberty:**

**Number of children:**

**Do you feel your libido is adequate?** ◯ Yes ◯ No

**Comments:**

**Do you wake at night to urinate?** ◯ Yes ◯ No

**How many times per night?**

| | | |
|---|---|---|
| **Do you have any difficulty and/or pain with urination?** | ◯ Yes | ◯ No |
| **Any diminished volume or flow?** | ◯ Yes | ◯ No |
| **Do you enjoy daily activities?** | ◯ Yes | ◯ No |
| **Do you feel apathetic or complacent about previously enjoyed sports, hobbies, clubs, games, etc?** | ◯ Yes | ◯ No |
| **Do you notice feeling more agitated/irritable than previously?** | ◯ Yes | ◯ No |
| **Do you feel less assertive in daily life than previously?** | ◯ Yes | ◯ No |
| **Do you feel your muscle tone has been decreasing?** | ◯ Yes | ◯ No |
| **Do you feel any positive or negative shifts in testosterone?** | ◯ Yes | ◯ No |

Loss/gain of muscle tone, shift in libido, etc.

**If so, when did this change occur?**