NOURISH
holistic health & nutrition

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INITIAL CONSULT CONFIDENTIAL CLIENT HEALTH QUESTIONNAIRE

Consultation Date: _____ Consultation Time: _____

** All of your personal information will remain strictly confidential**

Contact Information:

Name: _____ Date: _____
E-mail Address: _____
Street Address: _____
Mailing Address (if different): _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Date of Birth: _____
Place of Birth: _____

How did you hear about NHHN? Referred by? (be specific)

_____

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

_____

Background:

Age: _____ Gender: _____ Height: _____ 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 that you'd like to address:

1._____
2._____
3._____

4._____
5._____
_____

Sleep:

What time do you typically go to sleep? _____ Do you sleep well? _____
What time do you typically wake up in the mornings? _____
Do you remember your dreams? _____
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 you have experienced them:

Bloating Heartburn Indigestion Gas Acid Reflux Constipation Diarrhea

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

_____

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 type of cookware do you use (cast iron, aluminum, etc) _____
What types of fats do you typically cook with (olive oil, butter, ghee, coconut oil, etc)
_____

Do you crave sugar? _____ Do you crave salt? _____
Do you feel tired, bloated, and/or gassy after meals? _____
Do you feel excessively hungry? _____ Do you have a poor appetite? _____
Do you drink caffeinated drinks, how much/how often? _____
Do you drink soda (diet or regular)? _____
How much water do you drink per day (in ounces)? _____

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

Do they sink or float? _____
Do you tend to have foul smelling gas? _____

Toxin Exposure

Do you smoke? _____ How much & how often? _____
Exposure to Secondhand Smoke? _____ If so, how much and how long?_____
Do you drink alcohol? How much/how often? _____
Have you been exposed to toxic substances at work or home (mold, cleaning supplies, heavy metals,etc)_____
Do you have any amalgam filings? _____If yes, have they been replaced or removed?_____

Health History:

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 below including name brands and amounts:*

_____
_____

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?

_____
_____

Please briefly describe your medical history (surgeries, accidents, diseases, dental procedures (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? If so what order are you?_____
Were you born vaginally or by cesarean?_____
Were you full term, pre-mature, late?_____
Were you breast fed? If yes, until when? _____if no, were you formula fed?_____

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)
_____
Do you have a history of over-exercising?_____
Do you feel you have a positive relationship with movement and exercise?_____
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 (circle one)? 1=low and 10=high

1 2 3 4 5 6 7 8 9 10

Family Health History:

Fill the following with yes or no AND relationship to family member:

Diabetes:	Kidney Disease:	Asthma:
Heart Disease:	Arthritis	Gallbladder Disease:
Cancer, and Type:		
Stomach/Intestinal Disorders:		
Other:		

Mother's Age: Died From:
Father's Age: Died From:

Maternal Grandmother's Age: Died From:
Maternal Grandfather's Age: Died From:

Paternal Grandmother's Age: Died From:
Paternal Grandfather's Age: Died From:

Additional Questions:

Do you have light headedness when you bend over or stand up? _____
Do you ever have any ringing in your ears? _____
Do you ever experience any dull/achy low back pain?_____
Do you have any sensitivity to light &sound?(for example, always feeling like you need to wear sunglasses?) _____
Have you experienced any previous trauma? A simple yes/no answer is perfectly accepted

_____

Women Only:

Age of your first period: _____ Are your periods currently regular? _____
Were they regular when they first started? _____
How frequent are your periods on average? _____
How many days in your flow? _____
How many days is your (full) cycle? _____
Please circle which best matches your monthly flow: *light* *medium* *heavy*
Number of Pregnancies: _____
Do you experience PMS? _____
Is your PMS mild or severe? _____

Are you on any form of birth control (pill, IUD) _____
Are you peri-menopausal? _____ When did this change first start? _____
Are you menopausal? _____
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? _____
Please explain:

_____

Did you receive antibiotics during labor? _____

Are you currently pregnant or looking to become pregnant? _____
Are you currently having or have you ever had issues with fertility?_____
Have you ever had a miscarriage or an abortion? _____ How many? _____
Do you feel your libido is adequate? (yes/no)_____

Men Only:

Approximate age of onset of puberty: ____ Number of Children: _____
Do you feel your libido is adequate? (yes or no) _____
Comments: _____
Do you wake at night to urinate? _____ How many times per night? _____
Do you have any difficulty and/or pain with urination? (yes or no) _____
Diminished volume or flow? (yes or no) _____
Do you enjoy daily activities? _____

Do you feel apathetic or complacent about previously enjoyed sports, hobbies, clubs, games, etc.?

_____

Do you notice feeling more agitated/irritable than previously? _____

Do you feel less assertive in daily life than previously? _____

Do you feel your muscle tone has been decreasing? _____
Do you feel any positive or negative shifts in testosterone (loss/gain of muscle tone, shift in libido)? If so when did this change occur? _____