Client Health Questionnaire

Personal History

Name: ____

What are your Goals for this visit?

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____
____
____
____

Please list any specific health concerns:

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____
____
____
____
____

Have you ever visited a holistic health practitioner before? ________________________
If yes, why?

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____
____
____
____
____

Occupation:

____
____

Household Members:

____
____
____
____
____

Client Health Questionnaire

Physical Activities (Please include duration and times a day/week/month):

____
____
____
____
____
____

Hobbies:

____
____
____
____

Do you have any major stress in your life? If yes, what type?

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____
____
____
____
____

In what ways do you relax?

____
____
____
____

Do you participate in any Spiritual Practices/Religious Communities?

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____
____
____

In what ways do you cultivate a sense of comfort or ease in your life?

____
____
____
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____
____

Client Health Questionnaire

Medical History

Please answer yes or no if you have or have had any of the following conditions:

Addiction: ________

Arthritis: ________

Anxiety Disorders: ________

Asthma: ________

Allergies: ________

Blood Clots: ________

Cancer: ________

Cardiovascular Disease: ________

Depression: ________

Diabetes: ________

Digestive Disorders: ________

Heart Attack: ________

Headaches: ________

High Blood Pressure: ________

High Cholesterol: ________

Sinusitis: ________

Skin Diseases: ________

Other: ________

Other: ________

Other: ________

Client Health Questionnaire

Please list if there is a family history of any of the conditions from the previous page:

____

Please list any major surgeries or injuries:

List all medications and reasons for taking them:

List all supplements/herbs and reasons for taking them:

Do you have any allergies? If yes, to what and what are the symptoms of the reactions?

Client Health Questionnaire

Nutritional Health and Habits

How many meals do you eat a day? What times do you generally eat these meals?

____

____

____

____

____

____

Do you generally eat alone or with family/friends/co-workers?

____

____

____

Do you participate in other activities while eating? (ex. Reading, Watching TV)

____

____

____

Do you skip meals often?

____

____

____

How many and how large a serving of fruits do you eat a day?

____

____

____

How many and how large a serving of vegetables do you eat a day?

____

____

____

Are you currently on a special diet? If yes, please explain.

____

____

____

Client Health Questionnaire

What are your main sources of protein?

What oils/fats do you use as spreads and/or to cook with?

How much water do you drink a day?

How many caffeinated drinks do you consume a day? A week?

Do you drink alcoholic beverages? If yes, how much and how frequently?

Do you smoke?

Do you use recreational drugs? If yes, which?

How often do you eat out? Where do you normally go? What do you order?

Client Health Questionnaire

Where do you grocery shop? How frequently do you go to this store?

Do you normally reach for sweet/sour/bitter/salty/spicy/bland?

Are there particular textures you lean towards? (crunchy/smooth)

Are there particular food temperatures you prefer? (hot/cold/room temperature)

Do you normally eat freshly prepared foods or more processed/pre-packaged food?

Do you notice seasonal changes in the above answers? If yes, what?

Client Health Questionnaire

Please recall what you have eaten in the last twenty-four hours, how it was prepared, and any fluids consumed. Please list as well any herbs/supplements/medications consumed in the last twenty-four hours:

Is this typical?