



# Initial Interview: Confidential Client Health Questionnaire

Consultation-Date: \_\_\_\_\_ Consultation Time: \_\_\_\_\_

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

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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: \_\_\_\_\_

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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? \_\_\_\_\_

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 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 or childhood diseases you have had along with the type and date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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? \_\_\_\_\_

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**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			

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**WOMEN ONLY:**

Age of your first period: \_\_\_\_\_ Are your periods regular? \_\_\_\_\_

How frequent? \_\_\_\_\_ # 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? \_\_\_\_\_

Please explain: \_\_\_\_\_

\_\_\_\_\_

Did you receive antibiotics during labor? \_\_\_\_\_

Have you ever had a miscarriage or an abortion? \_\_\_\_\_ How many? \_\_\_\_\_

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### **MALE ONLY**

Approximate age of onset of puberty: \_\_\_\_\_ # of Children: \_\_\_\_\_

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

Do you wake at night to urinate? \_\_\_\_\_ 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 notice 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? \_\_\_\_\_