# Health & Nutrition Client Assessment Form

*Please help us provide you with a complete & thorough evaluation by fully completing this questionnaire.*

**Date:**_____

**Name:**_____

Address:_____

City:_____ Province:_____ Postal Code:_____

***Contact Information*:**

H:_____ C:_____ W:_____

E-mail:_____

Age:_____ Height:_____ Gender: ☐ M ☐ F

Status: ☐ Single ☐ Common-Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you have children? ☐ N ☐ Y *If yes, how many and ages:*_____

**Emergency contact name:**_____

Relationship:_____ Tel: H_____ W_____

**Physician:**_____ Tel:_____

## Primary Concerns

**Main concerns:**_____

How long have you had this/these issues?_____

Have you been diagnosed with any conditions by your doctor?_____

How do these concerns affect your daily life (sleep, work, eating, etc.)?_____

Please list any illnesses/conditions for which you are currently receiving medical treatment and/or therapy:

## Your Medical History

List any previous surgery, hospitalization, medical procedures, and major traumas (accidents, falls, etc.):

_____

_____

_____

Have you had any organs removed? ☐ tonsils ☐ appendix ☐ gall bladder ☐ other _____

Food allergies/intolerances?_____

Environmental or seasonal allergies/sensitivities?_____

List any medications (prescription or over the counter) taken in the past or currently (ex. Antibiotics, blood pressure, cholesterol, antacids, HRT, oral contraceptives, thyroid medication, etc.):

| Medication | When Taken? | How long? |
|---|---|---|
| | | |
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| | | |

List all supplements, homeopathic remedies, herbs, or other natural remedies that you are currently taking:

| Supplement/Herb | Brand Name | Amount Taken | When Taken | How long? |
|---|---|---|---|---|
| | | | | |
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## Family Medical History

| Family Member | Age | General Health | Disease or illness |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Sibling | | | |
| Sibling | | | |
| Sibling | | | |
| Children | | | |
| Grandparent | | | |
| Grandparent | | | |

## General Health Information

Blood Type: ___ Weight: _____ Weight Gain/Loss in last year? *If so, how much?* _____
What is your energy level like during the day? *Please describe your best and worst times of the day*: _____
_____

Bowel Health: Number of bowel movements _____/day_____/week ☐ constipation ☐ diarrhea
General colour of bowel movement: _____
Any digestive issues? (gas, bloating, cramping, constipation, etc.)_____
_____

Have you experienced any of the following in the last year (or two)? *Please check all that apply:*

☐ Weight loss
☐ Weight gain
☐ Change in appetite
☐ Poor appetite
☐ Bruise easily
☐ Poor balance
☐ Problems falling asleep
☐ Issues staying asleep

Have you ever been diagnosed with any of the following conditions?

☐ Arthritis
☐ Anemia
☐ Emphysema
☐ Heart condition
☐ Irritable Bowel
☐ Cancer
☐ Fibromyalgia
☐ Diabetes
☐ Anorexia/Bulimia
☐ Epilepsy
☐ High/Low Blood Pressure
☐ Osteoporosis
☐ Prostate problems
☐ Chronic Fatigue Syndrome
☐ Thyroid condition
☐ Appendicitis
☐ Hepatitis
☐ Asthma
☐ Hypoglycemia
☐ Endometriosis
☐ Pneumonia
☐ Seizures
☐ Eczema
☐ Crohn's Disease
☐ Gall Bladder problems
☐ Psoriasis

Other (please specify): _____

***Females:***
Do you use birth control? ☐ Yes ☐ No *If yes, what type (pills, condoms, etc.)*_____
Have your periods ever stopped? *If yes, when and for how long?*_____
How long is your entire cycle? _____ Days Average number of days period lasts? _____ Days
Do you have PMS symptoms? ☐ Yes ☐ No
Do you have menopausal symptoms? ☐ Yes ☐ No

Do you smoke? ☐ Yes _____*# cigarettes per day* ☐ No Have you smoked in the past? ☐ Yes ☐ No
Are you exposed to second hand smoke? ☐ Yes ☐ No
Do you use recreational drugs? ☐ Yes __ # times per week ☐ No

How many silver amalgam fillings do you have? _____ How long have you had them? _____
How many root canals have you had? _____

Are you exposed to any chemicals or contaminants at work or elsewhere? Please list: _____
_____

Do you use any of the following? Please check all that apply:

☐ Perfume/Cologne
☐ Artificial sweeteners
☐ Luncheon meats
☐ Margarine
☐ Aluminum cookware
☐ Household cleaners
☐ Air fresheners
☐ Fast foods

## Lifestyle Information

How many cups (on average) of each do you drink?

| | | |
|---|---|---|
| Water _____ /day | Coffee _____ /day | Wine _____ /week |
| Milk _____ /day | Soft drink_____/day | Liquor _____ /week |
| Juice _____ /day | Diet soft drink ___ /day | Beer _____ /week |
| Tea _____ /day | Herbal tea ____/day | |

How often do you eat in restaurants or eat take out? _____
Who does the grocery shopping? _____
Who does most of the cooking? _____
Do you eat late at night (dinner after 8pm)? ☐ Yes ☐ No

Foods you crave most _____
Foods you crave least _____
5 Foods you eat most often _____
Dietary restrictions (vegetarian, vegan, no milk, etc.)_____
Do you currently exercise? ☐ Yes ☐ No *If yes, how long & how many times per week?*_____
_____

What makes you happy? _____
What makes you worry? _____

How many hours of sleep do you usually get each night?_____
How would you describe the quality of your sleep? ☐ Restful ☐ Somewhat restful ☐ Disrupted/restless
Do you wake up feeling rested? ☐ Yes ☐ No
Do you have a hard time falling asleep? ☐ Yes ☐ No

**What are your expectations of this program?**

**Are there any programs you have tried in the past that worked for you? Why did you succeed?**

**Is there anything else I should know? Do you have anything else you want to make sure is addressed in your sessions?**

## Nutrition 3-day food diary

| | Day 1 | Day 2 | Day 3 |
|---|---|---|---|
| Breakfast | | | |
| AM Snack | | | |
| Lunch | | | |
| PM Snack | | | |
| Dinner | | | |
| Snack | | | |
| Daily Fluids | | | |

_____ _____

*Signature (client or legal guardian)* *Date*

***Thank you for taking the time to give us this valuable information!***