FOUR SEASONS NUTRITION

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CLIENT QUESTIONNAIRE

(CONFIDENTIAL)

Name: _____Date: _____

Address: _____

Home Phone No.: _____ Cell Phone No:_____ Fax No: _____

E-mail: _____ Referred By: _____

Age: _____ Date of Birth: _____ Place of Birth:_____ Ethnicity:_____

Height: _____ Weight: _____ Body Frame: _____ Blood Type: _____

Do you consider yourself underweight, overweight, or just right? Please circle your choice.

Have you experienced unexplained weight loss or weight gain of 10 pounds or more in the last three months?

_____

Do you now have or have you ever had an eating disorder?_____

Do you smoke now or have you smoked cigarettes in the past?_____

Do you regularly consume alcohol? If so, what and how much?_____

Do you regularly drink coffee? If so, how much and how often? _____

Do you regularly use recreational drugs? If so, what, how often and how much? _____

Living Situation: Please circle one (Single/Married/Divorced/Children/Significant others):

Comments: _____

Occupation: _____How Long? Prior Occupation:_____

Health Concerns:_____

_____

What do you want to work on? _____

_____

If on the cancer journey, please indicate the type of cancer, when diagnosed, treatment and dates and any other relevant info, use the back if

needed:_____

_____

Physician/Chiropractor/Acupuncturist/Massage Therapist/Other Health Practitioners: (Please list names of Health Professionals you are currently seeing or have seen). Use other side if necessary.

_____

_____

_____

Medications currently taking, prescription & over the counter (Name, how much, how often, how long, for what, prescribed by whom?), Medications taken in the past? Use other side if necessary.

_____

Supplements/Herbs currently taking (Name, how much, how often, how long, for what, recommended by whom?) Use other side if necessary.

_____

_____

Most recent laboratory tests: (Please list tests and dates if known.) Use other side if necessary.

_____

_____

Past Major Illnesses/Injuries/Traumas/Hospitalizations: (Please indicate year):

_____

_____

Do you have silver dental fillings? Yes ____ No ____

Describe your sleep patterns, check one: Usually sleep well _____ Wake up frequently_____

If you wake up frequently during the night, about what time do you wake up? _____

Do you have trouble falling asleep? Yes ____ No ____

Do you have trouble staying asleep? Yes ____ No ____

Do you feel rested upon waking up? Yes ____ No ____

Do you have any other comments about your sleep patterns? _____

_____

Describe frequency of bowel movements. Check which applies:

Usually occur: once a day ___, twice a day ___, more than twice a day ___, more than 3 times a day ___,

every other day ___, every 2-3 days ____, once a week ____Other _____

If female, describe your monthly menstrual cycle: _____

_____

If female & no longer cycling, what were your periods like when you had them?_____

_____

Indicate level of happiness on a scale of 1-10 with 1 being the lowest: 1 2 3 4 5 6 7 8 9 10

Indicate your level of stress on a scale of 1 to 10 with 1 being the lowest: 1 2 3 4 5 6 7 8 9 10

What are the major causes of stress?_____

_____

Indicate average energy level on a scale from 1 to 10 with 1 being the lowest: 1 2 3 4 5 6 7 8 9 10

Does energy level vary? Describe: _____

_____

Have you been and are you now being exposed to harmful chemicals (pesticides, radioactivity, solvents, chemicals, hair dyes, paints, cleaning supplies, other products?) Yes ____ No ____

Explain: _____

Family Medical History. Please indicate any known health disorders experienced by your parents, siblings, and extended family: _____

_____

Is there any other information that you would like to share that may be helpful and relevant?