



Stand Tall · Be Sweet · Wear Your Crown

## 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:

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



## 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:* \_\_\_\_\_

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

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Weight loss        | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Problems falling asleep |
| <input type="checkbox"/> Weight gain        | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Issues staying asleep   |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Poor balance  |  |

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

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

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: \_\_\_\_\_

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

- |  |   |
|--|---|
| <input type="checkbox"/> Perfume/Cologne       | <input type="checkbox"/> Aluminum cookware  |
| <input type="checkbox"/> Artificial sweeteners | <input type="checkbox"/> Household cleaners |
| <input type="checkbox"/> Luncheon meats        | <input type="checkbox"/> Air fresheners     |
| <input type="checkbox"/> Margarine             | <input type="checkbox"/> 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?**

\_\_\_\_\_  
Signature (client or legal guardian)

\_\_\_\_\_  
Date

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