Nutritional Consult Questionnaire

Please set aside 10-15 minutes to fill out this questionnaire in its entirety. This information is collected and reviewed in order for us to develop an optimal holistic health plan that is unique to you and complimentary to your lifestyle.

All information gathered is completely confidential and is protected under the privacy act. It is important that you are as *candid and accurate* as possible in order to get the most out of your program.

CLIENT INFORMATION

FULL NAME _____ DATE OF BIRTH _____ _____ _____
MM DD YYYY

PHONE _____ ALTERNATE PHONE _____EMAIL _____

Would you like to receive a monthly newsletter via email with holistic health and research information, recipes and specials?

☐ YES ☐ NO

SEX ☐ M ☐ F HEIGHT _____ WEIGHT _____

What is your level of physical activity? ☐ SEDENTARY (office job, little additional exercise)

☐ MODERATE (office job, exercise 3x/week) ☐ ACTIVE (physically demanding job, exercise 3x/week)

☐ VERY ACTIVE (physically demanding job & exercise 4-6x/week)

ADDRESS:

NO. & STREET _____ APT/UNIT# _____

CITY/TOWN _____PROVINCE _____POSTAL CODE _____

HOW DID YOU HEAR ABOUT US? ☐ REFERRAL ☐ AD ☐ WEB/FACEBOOK ☐ OTHER

If you were referred to us by a friend or family member please provide us their name so we can send them a letter of thanks:

_____

HEALTH CONCERNS

Please list your main health concerns at the present time (chronic pain, weight loss, digestion, high cholesterol, sports nutrition etc.)

Do you have any complaints about the following? (Please check all that apply):

APPETITE ☐ CONSTIPATION ☐ ACID REFLUX ☐ BLOATING and/or GAS ☐ DIARRHEA ☐

OILY SKIN ☐ BAD BREATH ☐ EXCESSIVE BODY ODOR ☐ FOUL ODORED STOOL ☐

HEMORRHOIDS OR ANAL FISSURE ☐ NAUSEA ☐ PAINFUL BOWEL MOVEMENTS ☐

DRY HAIR/SKIN and/or NAILS ☐ JOINT and/or MUSCLE PAIN ☐ HEART PALIPITATIONS ☐

NERVOUSNESS and/or IRRITABILITY ☐ COLD HANDS and/or FEET ☐ SENSITIVE TEETH ☐

ACNE ☐ STERILITY or IMPOTENCE ☐ DEPRESSION ☐ HEADACHES ☐ DIZZINESS ☐

EYE and/or FACE PUFFINESS ☐ SINUS ISSUES ☐ ECZEMA, PSORIASIS, RASH or DERMATITIS ☐

MENSTRUAL DISCOMFORT ☐ LOW SEX DRIVE ☐ FOOD ALLERGIES/SENSITIVITIES ☐

PMS ☐ UNUSUAL CRAVINGS FOR SUGAR/BREAD/ALCOHOL ☐ LOW ENERGY ☐

HEALTH HISTORY

List all health conditions and/or diseases you have been diagnosed with recently and as far back as birth.

List all of your current medications (and medications you have taken in the past 12 months).

_____

_____

_____

List all of your current supplements (vitamins, minerals, herbs, combination products).

_____

_____

_____

How many times (approx.) have you taken antibiotics since childhood _____

List all medical conditions (high cholesterol, diabetes, heart disease, cancer) of parents, siblings and grandparents.

_____

_____

_____

_____

Do you exercise? ☐ YES ☐ NO If yes, how many days per week? _____

Is your work physically demanding? ☐ YES ☐ NO

How many hours of sleep each night do you get on average? _____

Do you drink caffeinated beverages (coffee, tea, soda)? ☐ YES ☐ NO

Do you use artificial sweeteners (splenda, xylitol, aspartame)? ☐ YES ☐ NO

Does your energy level change throughout the day (ex: morning low, afternoon high, evening low, after midnight high)? ☐ YES ☐ NO

Please indicate any allergies or sensitivities (food and environmental):

_____

_____

_____

How many bowel movements do you have per day? _____

Do you have any food cravings? If yes, list all of them:

_____

_____

Do you have any dietary restrictions due to religious beliefs, culture or otherwise? If so, please list all of them (vegan, kosher, no dairy etc.)

_____

_____

_____

Are there any foods you are NOT willing to give up?

_____

_____

Is there any food or beverage you feel addicted to?

_____

_____

Do you smoke or use smoking cessation products (gum, patch)? ☐ YES ☐ NO

Do you consume alcohol? ☐ YES ☐ NO If yes, how much and how often? _____

Do you use recreational drugs? ☐ YES ☐ NO

How many glasses of water do you consume daily? _____

What is the source of your water? ☐ TAP ☐ FILTERED ☐ BOTTLED ☐ DISTILLED ☐ SPRING

Please indicate how many of these meals you eat each day:

☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ AFTERNOON SNACK ☐ DINNER ☐ NIGHT SNACK

Do you eat more or less in stressful and emotional times? _____

Do you eat when bored, angry, sad and/or happy? ☐ YES ☐ NO

Indicate your stress level on an average day (1 being low, 10 being extreme) :

Do you have or have you ever had an eating disorder? ☐ YES ☐ NO

Please list any and all major and minor surgeries you've had since birth:

Do you have children (biological or otherwise)? ☐ YES ☐ NO If yes, how many? _____

FOR WOMEN ONLY

Do you experience PMS (cramps, bloating, mood change, aches and pains)? ☐ YES ☐ NO

Are you periods normal, heavy, heavy with clots or light? _____

How many days on average does your period last? _____

Do you experience any strong food cravings before or during your period? ☐ YES ☐ NO

Do you experience acne before or during your period? ☐ YES ☐ NO

Do you experience menopausal symptoms? ☐ YES ☐ NO

Are you post menopause (finished menstruation)? ☐ YES ☐ NO

How often do you have a menstrual cycle per year? _____

Are you currently using birth control? ☐ YES ☐ NO If yes, how many years? _____

Are you currently on hormone replacement therapy? ☐ YES ☐ NO

Have you given birth? ☐ YES ☐ NO If yes, how many times? _____

Have you had a miscarriage? ☐ YES ☐ NO If yes, how many? _____

Do you have melasma (dark patches of skin) on your face? ☐ YES ☐ NO

YOUR EXPECTATIONS

What are you expecting from your visit?

Have you tried any nutrition programs, exercise routines or diets in the past that were successful for you or that you particularly enjoyed doing? What did you like about them?

Is there a particular goal you would like to focus on (eat healthier, lose 20 pounds, develop a custom supplement protocol, meal planning etc.? Be as specific as you'd like.

Please indicate any other comments or areas you would like covered in your session:

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

We look forward to helping you Take Control of Your Health!