

**Initial Interview: Confidential Client Health Questionnaire**

# Consultation Date: Consultation Time:

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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:

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?

Do you have any allergies?

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?

# 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 |  |

**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?

# 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 notices 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?