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Healthy Life Transformations

Confidential Client Health Questionnaire

Consultation Date _____

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

Name: _____ E-mail Address: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Work/Cell Phone: _____ Age: _____ Date of Birth: _____

Place of Birth: _____ Gender: _____

Height: _____ Weight: _____ Blood Pressure: _____

Would you like your weight to be different? _____ If so, what? _____

Occupation: _____ How many hours do you work per week? _____

Relationship Status: _____ Children? _____

Referred to by: ☐ Facebook ☐ Google/Our Website ☐ Other: _____

What is your preferred method of communication? ☐ Phone Call ☐ Text Message ☐ Email

What are your health concerns? _____
_____

_____

What would you like to accomplish/gain from this consultation (goals)? _____

_____

___

Do you sleep well? _____ Do you wake up during the night? _____

If so, what time(s)? _____ What time do you go to bed? _____

What time to 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 second hand smoke? _____ If so, how long? _____

Do you drink alcohol? _____ How much & how often? _____

Do you drink soda (diet or regular)? _____ How much and how often? _____

What role does exercise play in your life? _____

How much water do you drink per day? _____

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/non-prescription medications, aspirin, laxatives, diet pills or any other supplements? Please list below including name brand 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 you eating habits like as a child? (List types of food)

_____

_____

What percentage of 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? _____

Do you have regular bowel movements at least once a day? _____

Do you feel excessively hungry? _____ Do you have a poor appetite? _____

Family Health History (Indicate with 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	

<u>WOMEN ONLY</u>:

Age of your first period: _____ Are your periods regular? _____

How frequent? _____ Number of pregnancies? _____

How many days is your flow? _____

Do you experience PMS? _____ If so, 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 (vaginal or by cesarean)?
_____
_____

Were there any complications associated with these births? _____
Please explain: _____
_____

Did you receive antibiotics or epidural during labor? _____

Have you ever had a miscarriage or an abortion? _____How many? _____

DISCLAIMER

The health and nutritional information you receive from any Functional Nutritional Therapy Practitioner (FNTP) during a consultation, whether given by phone, in person at your home, in the office, through lectures, workshops, brochures, or newsletters is not intended to diagnose or prescribe. It consists of combined information from many educational sources and points of view to help you make informed decisions regarding your desired level of health. The sources behind this information include: modern medicine, ancient Chinese medicine, naturopathic medicine and the therapist's personal research, study, and life observation as well as client results and experiences. Anyone deciding to act upon any information mentioned during a consultation shall assume full responsibility for any effects of their actions. There are risks and unforeseen results associated with any change of diet and lifestyle. It is not recommended that you apply these changes unless you are willing to assume full responsibility for the risks you choose to take. If you choose to implement dietary and lifestyle changes without consulting your physician, which is your constitutional right, you are, in effect, prescribing for yourself. When in doubt of the appropriateness of any treatment, whether recommended to you by a practitioner or by your own intuition, please consult a physician. Consultation information should not be used as a substitute for a physician's advice. It is our hope that you do choose a physician who realizes the importance of a healthy diet and lifestyle choices in correcting imbalances in the body and who has experience in treating immune disorders and other health imbalances. Please be aware that you have the right to make your own health decisions based on any information made available to you. YOU are the driving force in guiding yourself on a path to radiant health!

ACKNOWLEDGEMENT

I accept the terms and conditions of this disclaimer. I acknowledge that any and all information given to me by my FNTP is used for educational purposes only. I also acknowledge that my FNTP does not claim to be a medical doctor and will not prescribe for or diagnose any disease or condition.

The preceding answers are true and correct to the best of my knowledge. If I experience any changes in my health or current medications, I will immediately communicate this information to my FNTP. I further acknowledge that I am fully responsible for any decisions and/or changes I make regarding my health and I will not hold my FNTP liable for my own decisions, any results of my decisions or any natural treatment or advice I may receive.

Client Name (print): _____

Client / Guardian (circle one)
Signature: _____Date: _____