PALO ALTO
NUTRITION

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_____

Best Phone #:_____Date of Birth:_____Age:_____

Gender:_____Place of Birth:_____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 gain from this consultation?_____

_____

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 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?_____

Exposure to Secondhand Smoke?_____If so, how and how long?_____

Do you drink alcohol?_____If so, 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?_____

_____

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 and which family member)

Diabetes		Kidney Disease		Asthma	
Heart Disease		Arthritis		Gallbladder Disease	

Cancer		Type of Cancer	
Stomach/Intestinal Disorders		Other	

Mother's age		Died from	
Father's age		Died from	

Maternal Grandmother's Age		Died from	
Maternal Grandfather's Age		Died from	

Paternal Grandmother's Age		Died from	
Paternal Grandfather's 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?_____If so, how many?_____

MALE ONLY

Approximate age of onset of puberty:_____# of children_____

Do you feel your libido is adequate? Y N Comment:_____

Do you wake at night to urinate?_____How many times per night?_____

Do you have 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 notice 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?_____