balancebody&soulnutrition

# 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:

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## Your Medical History

List any previous surgery, hospitalization, medical procedures, and major traumas (accidents, falls, etc.):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Have you had any organs removed? ☐ tonsils ☐ appendix ☐ gall bladder ☐ other ________________

Food allergies/intolerances?______________________________________________________
Environmental or seasonal allergies/sensitivities?____________________________________

List any medications (prescription or over the counter) taken in the past or currently (ex. Antibiotics, blood pressure, cholesterol, antacids, HRT, oral contraceptives, thyroid medication, etc.):

| Medication | When Taken? | How long? |
|---|---|---|
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List all supplements, homeopathic remedies, herbs, or other natural remedies that you are currently taking:

| Supplement/Herb | Brand Name | Amount Taken | When Taken | How long? |
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## Family Medical History

| Family Member | Age | General Health | Disease or illness |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Sibling | | | |
| Sibling | | | |
| Sibling | | | |
| Children | | | |
| Grandparent | | | |
| Grandparent | | | |

## 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:* ______
________________________________________________________________________________

Bowel Health: Number of bowel movements ______/day______/week ☐ constipation ☐ diarrhea
General colour of bowel movement: __________
Any digestive issues? (gas, bloating, cramping, constipation, etc.)______________________________
________________________________________________________________________________

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

☐ Weight loss
☐ Weight gain
☐ Change in appetite
☐ Poor appetite
☐ Bruise easily
☐ Poor balance
☐ Problems falling asleep
☐ Issues staying asleep

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

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

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: _______________
________________________________________________________________________________

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

☐ Perfume/Cologne
☐ Artificial sweeteners
☐ Luncheon meats
☐ Margarine
☐ Aluminum cookware
☐ Household cleaners
☐ Air fresheners
☐ Fast foods

## Lifestyle Information

How many cups (on average) of each do you drink?

Water _______ /day
Milk _________ /day
Juice _________ /day
Tea __________ /day

Coffee _______ /day
Soft drink______/day
Diet soft drink ___ /day
Herbal tea ____/day

Wine _____ /week
Liquor ________ /week
Beer _________ /week

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 us this valuable information!***