



Inside Out Nutritional Therapy

CONFIDENTIAL CLIENT HEALTH QUESTIONNAIRE

DATE: _____ TIME: _____

All of your personal information will remain strictly confidential.

Name: _____ Email: _____
FIRST LAST

Address: _____
STREET CITY STATE POSTCODE

Phone: _____ DOB: _____ Place of birth: _____
HOME MOBILE

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: _____

What are your health concerns?

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

Do you sleep well? ☐ YES ☐ NO Do you wake up during the night? ☐ YES ☐ NO If so, what time(s)? _____

What time do you generally wake up? _____ How do you feel when you wake up? _____

Do you drink caffeinated drinks? ☐ YES ☐ NO How much & how often? _____

Do you smoke? ☐ YES ☐ NO How much & how often? _____

If NO, why, how and when did you quit smoking? _____

Exposure to secondhand smoke? ☐ YES ☐ NO If so, how & how long? _____

Do you drink alcohol? ☐ YES ☐ NO 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? _____

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/nonprescription 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? YES NO
☐ ☐ Please list all:

Are you currently under a practitioner's care for a specific health issue? YES NO
☐ ☐

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? ☐ YES ☐ NO Do you crave salt? ☐ YES ☐ NO

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? ☐ YES ☐ NO Do you have a poor appetite? ☐ YES ☐ NO

Family Health History (Indicate YES with a tick)

☐ Diabetes ☐ Kidney Disease ☐ Asthma ☐ Cancer Type: _____
☐ Heart Disease ☐ Arthritis ☐ Gallbladder Disease ☐ 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? ☐ YES ☐ NO How frequent? _____

of pregnancies: _____ How many days is your flow? _____

Do you experience PMS? ☐ YES ☐ NO Is it mild or severe? _____

Are you peri-menopausal? ☐ YES ☐ NO When did this change first occur? _____

Are you menopausal? ☐ YES ☐ NO 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? ^{YES NO} ☐ ☐

Please explain: _____

Did you receive antibiotics during labor? _____

Have you ever had a miscarriage or an abortion? ^{YES NO} ☐ ☐ How many? _____

MALE ONLY

Approximate age of onset of puberty: _____ # of children: _____

Do you feel your libido is adequate? ^{YES NO} ☐ ☐ Comments: _____

Do you wake at night to urinate? ^{YES NO} ☐ ☐ How many times per night? _____

Do you have any difficulty and/or pain with urination? ^{YES NO} ☐ ☐ Diminished volume or flow? ^{YES NO} ☐ ☐

Do you enjoy daily activities? ^{YES NO} ☐ ☐

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? _____

Notes: