Nutritional Therapy Association, Inc.®

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: _____

_____

_____

Have you had and dental procedures done i.e. fillings, root canals, pulled teeth, crowns, etc.?

_____

_____

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?_____