CLIENT HEALTH EVALUATION

Name: _____ **Date:** _____

Address: _____

City: _____ **Prov:** ____ **Postal Code:** _____

Phone No. and Type (best): _____ **Alternative:** _____

Email: _____ **Birth date:** _____

Who referred you to me: _____

Client Description

Gender: _____ **Height:** _____ **Weight:** _____

Body Frame (S, M, L): _____ **Marital Status:** _____

Children and Ages: _____

Family/Living Situation: _____

Occupation: _____ **Full-time, Part-time, Other:** _____

Exercise/Recreation and # of times/week: _____

Health Concerns

Describe onset and occurrence of health problems.

How have you dealt with these concerns in the past (doctors, self-care)?

What other health practitioners are you currently seeing?

List any medicine or supplements you are currently taking.

Have any other family members had similar problems (describe)?

Health Hazards

Describe any noticeable correlation between your problems and stress (work, family, relationships, financial).

List any toxicity—exposures and sensitivities to chemicals (tap water, air pollution, job and home exposures, cosmetics, food and chemical residues, e.g., Nutrasweet, and medicines including aspirin, birth control, etc.).

List any trauma (unresolved, physical and/or emotional wounds or abuse). What re-stimulates it? How does it affect your diet and health habits?

Describe any mal-nutrition (periods of eating junk food, binge eating, dieting).

List any addictive behaviors (past or present use and abuse of alcohol, drugs, tobacco, caffeine, co-dependency, workaholic, etc.).

Dietary Habits and Choices

What were your diet and family eating habits like growing up?

Describe your daily diet. What do you typically eat for breakfast, lunch and supper (and times)

How has your diet changed in relationship to your health problems? (Special diets?)

Describe the foods you eat (comfort foods) when you are:

1. Hungry:
2. Angry:
3. Lonely:
4. Tired:
5. Depressed:
6. Celebrating:

How is your mood and energy level affected by eating these foods (nourishing or numbing)?

What foods are your favorites? Include favorite fruits, vegetables, etc.

Do you have any allergies or strong dislikes to any foods?

Lifestyle, Mood and Energy

How is your sleep? Can you get to sleep easily? Can you stay asleep?

For women: How are/were your cycles? Do/did you have PMS? Painful periods?

How are your moods in general? Do you experience more anxiety that you wish? Depression? Anger?

On a scale of 1 to 10, 1 being the worst and 10 being the best, describe your usual level of energy (circle one): 1 2 3 4 5 6 7 8 9 10

What are your health goals?