Thank you for taking the time to fill out the following questionnaire. Please be as honest and detailed as possible, as this is very helpful in addressing your health concerns and will ensure the most from your consultation. I look forward to working with you and helping you achieve Optimal Health, Wellness and Vitality!

Note: All information gathered is completely confidential and will not be shared with any third parties.

Client Information

Full Name: _____ D.O.B. _____/_____/_____

Phone # _____ Month Day Year

Email _____

Marital Status _____ Children?_____ If Yes, how many?_____

Mailing Address:

Street _____ Apt/Suite # _____

City/Town _____ Province _____

Postal Code/ZIP _____ Country _____

Main Health Concerns

Please list your main health concerns (Digestion, skin health, diagnosed illness, weigh loss/gain, sports nutrition etc…)

Your Health History

List any health diagnosis you have received in your past/present.

List all health issues of parents or siblings (diabetes, cancer, high blood pressure etc..)

Please check any symptoms you are currently experiencing:

☐ Hay Fever ☐ Headache ☐ Itchy eyes ☐ Skin rash ☐ Brittle nails

☐ Runny Nose ☐ White spots on nails ☐ Ridges on nails ☐ Dry scalp

☐ Red bumps on back of arms ☐ Oily skin ☐ Itchy skin ☐ Coated tongue (white)

Are you seeing any other Healthcare Practitioners? Please check any that apply

☐ Medical Doctor ☐ Dentist ☐ Naturopath ☐ Acupuncturist

☐ Psychiatrist ☐ Chiropractor ☐ Massage Therapist ☐ Osteopath

☐ Herbalist ☐ TCM -Chinese Dr./Medicine ☐ Homeopathic Doctor

Have you ever been on antibiotics?_____ If so how many times in the past 10 years?_____

Please list all your current medications:

Medication	**Duration**	**Reason/Condition**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all your current supplements (vitamins, minerals, herbs etc..)

Natural Health Supplement	**Dose**	**Duration**	**Reason/Condition**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_ _____	_____	_____
_____	_____	_____	_____

Hours of Sleep per night: _____

Do you wake up throughout the night? ☐YES ☐NO

Do you wake up feeling rested? ☐YES ☐NO

Indicate your level of energy on a scale of 1-10 (1 being LOW, 10 being HIGH) _____

Do you exercise? ☐YES ☐NO If yes, please indicate how often and what kind of exercise/activity you do

Do you drink caffeinated beverages (coffee, soda pop, tea) If so, how many per day/week?

☐YES ☐NO _____ per day _____ per week

Do you drink carbonated beverages? If so, how many per day/week?

☐YES ☐NO _____ per day _____ per week

Do you drink Diet Drinks or artificial sweeteners (Splenda, aspartame, sugar twin etc.)?

☐YES ☐NO

How many glasses of water do you drink per day? _____

Do you have any known allergies or food intolerances ? Please list any below.

Do you experience any of the following digestive concerns or have had any in the past?

☐Bloating ☐Gas ☐Cramping ☐Constipation ☐Loose stools ☐Diarrhea

☐Heartburn ☐Indigestion ☐Urgent/frequent bowel movements ☐Blood in your stool

How many bowel movements do you have a day? _____

Please list any cravings you have:

List top **Five** foods you eat most often:

Are there any foods you are NOT willing to give up? If so, please list them

Do you have any dietary restrictions? For example: no red meat, vegan, no dairy, etc… Please be specific

Do you tend to eat MORE or LESS when stressed? _____

Do you consume alcohol? If Yes, how many drinks per day/week/month

☐YES ☐NO _____day _____week _____month

Do you smoke? If Yes, how much/often?

☐YES ☐NO

Do you use any recreational drugs? If Yes, how much/often?

☐YES ☐NO

Indicate your level of stress (1 being low, 10 being high on an average day)

LOW HIGH

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 5 10

Please list your sources of stress:

Do you eat for emotional or stressful reasons/events? ☐YES ☐NO ☐SOMETIMES

WOMEN ONLY _____

Are you on the birth control pill? ☐YES ☐NO If yes, how many months/years?

_____ _____

Months Years

Are you on any form of hormone ☐YES ☐NO If yes, how many months/years?

replacement therapy _____ _____

(Synthetic or Natural?)_____ Months Years