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new client questionnaire

date: _____

name: _____ birth date: _____

address: _____

_____

phone h: _____ marital status _____

w: _____ occupation: _____

c: _____ employer: _____

e-mail: _____ # hours/week: _____

emergency contact:
relationship to you:
h:
c:
w:

current healthcare practitioners

name	title	phone	reason for seeing her/him	permission to contact?
				Y / N
				Y / N
				Y / N

family health history

	living(Y/N)?	age	health issues
mother's mother			
mother's father			
father's mother			
father's father			
mother			
father			
siblings			

referred by: _____

personal health

please answer as completely and honestly as possible... use back of sheet if needed

height: _____ blood pressure: _____
weight: _____ blood type: A B AB O don't know

Are you currently pregnant? Y / N
Are you currently breastfeeding? Y / N

Have you ever been on antibiotics? Y / N how many times? _____
Have you ever been on birth control pills? Y / N how long? _____

List all **medications, vitamins, herbs and homeopathics** you are currently taking, dosage, reason for taking, and for how long.

List all significant **health issues** you've experienced, include approx. dates.

surgeries?

dental history (include info about amalgam "silver" fillings)

Describe your **exercise** schedule.

How is your sleep? _____
Do you wake up refreshed? _____ Do you nap? _____

Do you have any allergies? *Y / N* *Use lines below to give details:*

Any skin issues? (eczema, acne, dermatitis...) *Y / N* *Use lines below to give details:*

food and drink

How much water do you drink per day? _____
How many meals do you have per day? _____

List any foods/drinks that you have daily. _____

Do you have any dietary restrictions at present, either self or physician imposed?
Y / N please explain. _____

Do any foods cause you physical symptoms? Y / N Please explain.

Do you use any of the following?:	Y / N	how much per day	details
alcohol			
tobacco			
soft drinks			caffeinated/noncaffeinated
coffee/ black tea			
sugar substitutes			brand:

Do you have diarrhea? Y / N How often? _____
constipation? Y / N How often? _____

How many bowel movements do you typically have in a day?

Is there anything else you would like to discuss?