New Client Information

Name_____

Date_____

Address_____

City_____ **State**_____ **Zip**_____

Home #_____ **Cell#**_____ **Work#**_____

E-Mail_____ **Occupation**_____

Referred By_____ **DOB**_____

Age:	Wt:	Ht:	BP:

What is your main complaint or area of interest?

_____

What are your nutrition and health related goals?

_____

Family History (check all that apply):

Stroke_____
High BP_____
Depression_____
Heart Disease_____
Arthritis (RA or OA)_____
Cancer___ Type?_____
Diabetes_____
Weight Problems_____
Ulcer_____
Psoriasis_____
Glaucoma_____
Family Side: ♀_____♂_____

Personal History (check all that apply):

- □ Arthritis
  - o RA
  - o OA
- □ Stroke
- □ High Cholesterol
  - o How High?_____
- □ High Blood Pressure
  - o How High?_____
- □ Diabetes
  - o Metabolic Syndrome
  - o Insulin Resistance
- □ Low Blood Sugar
- □ Chronic Fatigue
  - o Fibromyalgia
  - o Multiple Chemical Sensitivities
  - o Infectious Mononucleosis
- □ Frequent Colds/Flu
- □ Herpes/ HPV
- □ Cold Sores
- □ Cancer
  - o What type?_____
  - o Chemo?_____
  - o Radiation? _____
  - o Steroids?_____
- □ Surgeries
  - o What type?_____
- □ Thyroid Problems
  - o Hypothyroidism
  - o Hyperthyroidism
- □ Headaches
  - o Chronic Tension
  - o Migraines
  - o Cluster
  - o Hormonal
- □ Food Allergies
  - o To What?_____
- □ Seasonal Allergies
  - o To What?_____
- □ Medication Allergies
  - o To What?_____
- □ Sleep Problems
- □ Forgetfulness
- □ Hot Flashes
- □ PMS
- □ Birth Control Pills/ Hormones
- □ Weight Problems
- □ Constipation
- □ Diarrhea
- □ Abdominal Cramping/ Bloating
- □ Yeast Infections
- □ Low Libido
- □ Ulcers

Inside Out Health & Wellness
www.nourishyourself.abmp.com

440-554-0389
erin.healinghands@gmail.com

What Medications are you taking? List all please:

_____
_____
_____
_____

What Vitamins and herbal supplements are you taking? List all please:

_____
_____

Do you eat, drink, or use (circle all that apply):

Antacids	Protein Drinks	Appetite Suppressants
Aspirin	Alcohol	Coffee
Tylenol	Tap Water	Decaf Coffee
Ibuprofen	Bottled/filtered Water	Diet Soda
Laxatives	Tea	Soda
Refined Sugars	Candy	White Bread
Margarine	Butter	Fast Foods
Chewing Gum	Fried Foods	Chips
Salt (w/out tasting)	Tobacco	Cigarettes
Artificial Sweeteners	Energy Drinks	Coffee Creamers

List any food aversions and/or foods you dislike:

_____

Do you get noticeably irritated, weak, or lightheaded if you haven't eaten in a while?

_____

Do you crave certain foods? _____ What foods? Sweets? Chocolate? Bread/ Pasta? Fried Foods? Alcoholic drinks? Sodas/Diet Sodas? Meat?
Other? _____

Are you:
Under excessive amounts of stress_____ at home_____ at work_____
Physical Stress_____ Mental Stress_____
Exposed to chemicals regularly_____ Type_____
Exposed to smoke regularly_____

How often do you have bowel movements? _____ per day/ week/ month
Urinate? _____ per day

How is your dental health? Prone to Cavities? Gum Disease? Bleeding Gums?

_____

Are your nails week or brittle?_____

Average Sleep per night? _____

Any sleeping problems? _____

To what extent will you commit to achieving better health?
Little_____ Moderate _____ Major_____ Extreme_____

Is there anything else about either your health history or your current condition that you feel is important to mention?

_____
_____
_____

Inside Out Health & Wellness
www.nourishyourself.abmp.com

440-554-0389
erin.healinghands@gmail.com