



Health Evaluation Questionnaire

Date: _____

Name: _____ Date of Birth: _____ Gender: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Referred By: _____

Health History

Height _____ Current Weight _____ Desired Weight _____

Primary Care Physician: _____ Phone: _____

Address: _____

Last Physical: _____

Are you seeing any other practitioners? _____ Name: _____

Specialty _____

Have you had any serious accidents or surgeries? _____

How would you describe your health up until this time? _____

Did you miss much school as a child? _____ Do you miss much work? _____

If yes, reasons: _____

How have you dealt with your health issues? (Doctor, medication, alternative)

Do you get sick easily and take a long time to recover? _____

Do you get sick occasionally and recover fairly well? _____

Do you rarely get sick but recover rapidly if you do? _____



Present Health Concern

Describe your reasons for seeking nutrition consulting at this time _____

What are your hopes and goals from our work together? _____

What are your primary health concerns? _____

Symptoms: _____

How long have you had these concerns: _____

Have you been diagnosed by a doctor? _____

Was there anything different or particular about your life at the time of onset?

How have you addressed the concern until now? _____

Are you aware of anything that makes your symptoms better or worse? _____

Any times of the day you feel better: _____ worse: _____

Do you have family members with the same concern now or in the past? _____

Do any medical conditions run in your family? And what? _____

What prescriptions or over the counter medications are you taking? _____

How long: _____ For what reason: _____

What are the affects, negative or positive: _____

Who is overseeing the medication? _____

What vitamin, mineral, herbal or other supplements do you regularly take? _____

How long: _____



For what reason: _____

Affects, negative or positive: _____

Who is overseeing supplemental use? _____

How often do you have bowel movements? _____

Constipation? _____ Diarrhea? _____ Both? _____ Other? _____

Women: Do you have menstrual periods? _____ Painful? _____ PMS? _____

Number of day between periods? _____ Length of period: _____

Contraceptives? _____ What type: _____ Length of use: _____

Hormone replacement therapy? _____ What: _____ How long: _____

Do you get up during the night to urinate? _____ How often: _____

Men: Do you get up during the night to urinate? _____ How often: _____

Are you having any problems getting or maintaining an erection? _____

Lifestyle History

How much time do you devote to rest, self-care, personal time, recreation and creativity? _____

What do you do to relax? _____

Are you happy in your life at this time? _____

Who do you live with (include pets)? _____

Do you have quality time with family and friends? _____

Do you have adequate support? _____

What physical activities or exercise do you engage in? _____

Frequency? _____ Intensity? _____

How much sleep do you get on an average night? _____

Quality of sleep? _____

How is your energy level? _____

Does your energy fluctuate during the day? _____

Occupation: _____ #hours worked per week: _____

Do you like your job? _____



Do you, or have you worked or lived in an environment where you are exposed to pesticides, chemicals, heavy metals or other pollutants? _____

Do you regularly spray your house for pests or law for weeds? _____

Is there much stress in your life? _____

What causes the most stress? _____

How do you cope with stress? _____

Do you smoke, drink alcohol, or use recreational drugs? _____ Amount: _____

Diet History

What is your current eating pattern? _____

Do you enjoy the food you eat? _____ Do you have regular meal times? _____

Do you eat slowly and chew well? _____

Has your diet changed in regards to your current health concerns? _____

If so, how: _____

What was your diet like at the time your health concerns started: _____

Have you experienced periods of eating junk foods, restrictive dieting, or binge eating? _____

Explain when and how long: _____

How many times do you eat out each week? _____

How many times do you eat fast food each week? _____

Do you reach for certain foods/drinks to cope with stress or emotions? _____

What are your comfort foods? _____

Do you use artificial sweeteners? _____ Which ones? _____ how often: _____

What is your relationship with sugar? _____

Frequency: _____ Amount: _____

What were your typical diet and eating habits while you were growing up? _____



Describe a current typical day's diet: _____

Are you on a special diet? _____
What did you eat in the past 24 hours? (Included all meals, snacks, drinks, and how they were prepared). Was this a typical day? If no, why not: _____

How many glasses of water do you drink during a typical day? _____
Describe your appetite in the morning, afternoon and night? _____

How do you feel if you skip a meal or eat sugary foods? _____
Do you have food Sensitivities, allergies or restriction? _____

Do you crave the following foods? Sweets _____ Chocolate _____ breads _____
Fatty foods _____ salty foods _____ dairy _____ meat _____

How is our digestion? _____
After eating do you feel well nourished and energized or tired and sluggish?

Health Support

Describe what being healthy means to you? _____

Can you imagine being completely healthy? _____



How would your life be different? _____

Would you be willing to make changes to your current diet or lifestyle if you believed it would be beneficial to your health? _____

Do you have friends or family who will be supportive of you during your healing?

What is your desired health and activity outcome? _____

Please elaborate on any topics below:

This was a long journey through your health, diet and life style; thank you for taking the time to share it with me. Now we can begin.....

