Client Health Evaluation and Intake Form

(Please complete all sections and bring along to your appointment)

Nutritional Health Therapies

Personal Details

First Name				Date:	
Last Name:				Phone:	
Email:					
Address:					
D.O.B.:		Weight:		Height:	
Current Occupation:					
Hobbies:					
Overseas Travel in last 10 years:					
Pets:					

Family History of health conditions *(including allergies):*	
Mother:	
Grandmother:	
Grandfather:	
Father:	
Grandmother:	
Grandfather:	
Siblings:	

Client History - previous and current health conditions/virus/diseases *(Specify)*:

Current medications (prescribed):	
Vitamins/ minerals/ supplements/ herbs:	

Main health concerns/reason for appointment (please rank in order)	
1.	
2.	
3.	
4.	

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Sleep: Any sleep disturbance?	YES / NO (*Specify*):		
What time do you usually go to sleep?		Hours of sleep per night?	
Do you have a clock radio next to your bed?	YES / NO		
Do you use Wi-Fi before you go to sleep?	YES / NO		
Do you charge Mobile or iPad close to your bed?	YES / NO		

Upper Digestion *(Stomach)*:			
Do you experience: Heartburn	YES / NO	Burping / belching	YES / NO
Bloating	YES / NO	Burning/Pain in stomach	YES / NO
Other issues?			

Lower Digestion *(Bowels)*:	
How often do you have a bowel motion?	
Do you get constipated?	YES / NO
Do you feel fully evacuated?	YES / NO
Do you get diarrhoea?	YES / NO
Do you get flatulence more than normal?	YES / NO
Do you get mucus, blood, undigested foods in your bowel movement? *Circle relevant answer(s)*	
Is the stool colour: medium brown / dark brown–black / light clay / green tinge? *(Specify):*	
Other signs or issues (*Specify*):	

Urination:	
How often do you urinate per day?	Every 2 to 3 hours / more frequent / less frequent
Do you get a sense of urgency?	YES / NO
Do you get burning?	YES / NO
Dribbling?	YES / NO
Are you up at night several times?	YES / NO
Other issues?	

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Stress:	
Rate your current stress level on a scale of 1 to 10 (10 being the highest stress):	
What is the main reason(s) for your stress?	
If you are over stress level 5, what step(s) are you taking to reduce your stress level?	
What did you like to do in the past that has relaxed you?	
Do you exercise?	YES / NO / Infrequently

How many hours do you spend daily:	Watching TV?	
	Talking on a mobile phone?	
	Working on a computer / iPad or similar?	

Vaccinations?	
Please list any vaccinations you have had?	
Have you had injections of cortisone?	YES / NO
Do you have any metal implants in your body?	YES / NO

Recreational activities?	
Smoking / Alcohol / Drugs etc. (Specify frequency/quantity):	
Lived near factories, mines, farming?	YES / NO (*Specify*):
Contact with pesticides or herbicides or lived near crop spraying	YES / NO (*Specify*):

Allergies?

Do you have known allergies or reactions to foods, environment or medications?

(*Specify*):

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Sunlight:	
How much natural sunlight do you receive daily outside?	
Amount of sunlight you receive daily through windows?	
Hours spent daily under fluorescent lights?	

Eyes:		
Do you wear contact lenses?	YES / NO	If so, how many hours per day?
Glasses	YES / NO	If so, how many hours per day?

Emotional/psychological:

Do you experience depression, anxiety, phobias, panic attacks, mood changes:

(*Specify*):

Personal & Family History of major life events or traumas

(*Specify*):

Do you have concentration or learning difficulties? YES / NO

(*Specify*):

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Diet

Are there any particular foods or drinks that you would find it difficult not to have every day?

(*Specify*):

Do you have any strong favourites such as foods or drinks that you crave?

(*Specify*):

Are there any particular foods or drinks that you would say you are sensitive to?

(*Specify*):

Do you have sugar cravings? YES / NO	Do you have urgent hunger? YES / NO
What is your daily intake of sugar?	
What is your daily intake of coffee/tea?	
What is your daily intake of water?	
Do you drink filtered water?	YES / NO

24hour Food Recall	Week days (general food recollection)	Weekends (general food recollection)
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Dessert		
Fluids (water, coffee, tea, energy drinks, soft drinks etc.)		

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Women Only:

Are you pregnant? YES / NO		Are you trying to fall pregnant? YES / NO	
Method of contraception:		How long?	
Do you have monthly periods?		Date of last menstrual period?	
Are your monthly periods regular (28 day cycles)?	YES / NO	Other:	
Number of days of your menstrual flow?			

Circle any of the following symptoms you experience associated with your period:

Cramping, bloating, feeling weak, mood swings, cravings, heavy bleeding, back pain, headaches, bright red blood, dark clotty blood, hot flushes.

Are you going through menopause?	YES / NO	Have your periods stopped?	YES / NO

Other menstrual issues?
(*Specify*):

Is there anything else you would like to mention?

Thank you for your time with completing this form!