Confidential Client Information

Full Name _____ Nick Name _____ Date_____

Address (street, city, state, zip)_____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Gender_____ Date of Birth _____ Marital Status _____ Religious Preference_____

Name of Spouse/Significant Other_____ May we share health info with them? Y/N

Children's Names and Ages_____

Occupation _____ Employer_____

Known Allergies _____

In Case of Emergency Contact _____ Cell and Home # _____

Who referred you for your appointment today? _____

What is your chief complaint (reason for visit)? _____

_____

How long have you had this complaint?_____

Have you had similar issues? _____ Explain: _____

What have you done/used to get relief? _____

Have you traveled abroad recently? Y / N Where and When? _____

Current Medications and Dosage

Current Vitamins/Herbs/Supplements and Dosage

Current/Recent Physicians

Name	Specialty	Last Seen

Past Medical History

Have you had any major illness, injuries, falls, auto accidents, or surgeries? Women, please include information about childbirth (include dates) _____

_____

_____

_____

_____

Females only: What was the date of your last menstrual period? _____ Are you pregnant? _____

In the last year, what conditions have you been treated for by a physician:_____

_____

Please list any other health problems/hospitalizations you have had: _____

_____

Social History

Do you drink alcohol? _____ If yes, what type and amount per week?_____

Do you use tobacco or smoke? _____ If yes, what type and amount per day?_____

Did you ever use tobacco or smoke? _____ If yes, for how long and when did you quit? _____

Do you use recreational drugs? _____ If yes, what type and how often? _____

Do you consume caffeine? _____ If yes, what type and amount per day? _____

Do you exercise? _____ Describe: _____

What are your top 5 favorite foods? _____

What do you typically drink for beverages throughout the day? _____

What time do you go to bed? _____ How much do you sleep per night? _____ What position? _____

Do you have trouble falling asleep? Y / N Staying asleep? Y / N Bad dreams? Y / N Other?_____

How many hours per day do you perform the following? Lifting_____Sitting_____Bending_____Computer Use_____

Do you experience abnormally high amounts of stress? If yes, from what?_____

What are your hobbies? _____

How much daily energy (1 = lowest energy level; 10 = highest energy level) do you have?_____

How many hours of TV do you watch? Daily_____ Weekly_____

How many hours of spiritual enrichment each week? (Bible, prayer, church, etc.)_____

How many hours a week do you spend with family/friends?_____

Are you **truly** ready for change?_____ If no, what is holding you back and what support do you need to achieve your goals? _____

Family History

Is there any disease/illness in your family? (parents, siblings, children, aunts, uncles, grandparents) _____ If yes, list what they are and who suffered(s) from them: _____

_____

In particular, does anyone have: (If yes, write "F" for father, "M" for mother, "S" for sister, "B" for brother.)

____Heart Disease	____Lung Disease	____Liver Disease	____Kidney Disease
____Cancer	____Stroke	____Diabetes	____Asthma
____Tuberculosis	____Arthritis	____Chronic Pain	____Headaches
____Scoliosis	____Trouble Sleeping	____Mental Illness	

____Other:_____

Check the following conditions that apply to you, past and present. Add comments for clarification as needed.

Musculoskeletal
__Headaches
__Joint Stiffness/Swelling
__Spasms/Cramps
__Neck Pain
__Upper/Mid Back Pain
__Low Back Pain
__Shoulder, Neck, Arm, Hand Pain
__Hip, Leg, Foot Pain
__Chest/Rib Pain
__Numbness/Weakness
__Problems Walking
__Jaw Pain/TMJD
__Tendinitis
__Bursitis
__Arthritis
__Osteoporosis
__Scoliosis
__Bone or Joint Disease
__Other _____

Circulatory/Respiratory
__Dizziness
__Shortness of Breath
__Fainting
__Cold Hands/Feet
__Cold Sweats
__Chills
__Swollen Ankles
__Difficulty Lying Flat
__Pressure Sores
__Varicose Veins
__Blood Clots
__Heart Conditions/Chest Pain
__Palpitations
__Allergies
__Sinus Problems
__Asthma
__Cough
__Coughing Blood
__Wheezing
__Excessive Bleeding
__Pace Maker
__Lymph edema
__Other_____

Skin
__Rashes
__Itching/Burning
__Hives
__Eczema
__Athlete's Foot
__Warts
__Moles
__Acne
__Cosmetic Surgery
__Other_____

Gastrointestinal
__Gum Bleeding
__Nervous Stomach
__Indigestion
__Heartburn/Reflux
__Nausea/Vomiting
__Change in Bowel Patterns/IBS
__Constipation
__Diarrhea
__Jaundice
__Abdominal Pain
__Gall Bladder Problems/Removal
__Diverticulitis
__Crohn's Disease
__Colitis
__Other_____

Nerves/Eyes/ENT
__Numbness/Tingling
__Loss of Strength/Weakness
__Paralysis
__Twitching
__Chronic Pain
__Sleep Disorders
__Ulcers
__Herpes/Shingles
__Cerebral Palsy
__Epilepsy/Seizures
__Chronic Fatigue Syndrome
__Multiple Sclerosis
__Muscular Dystrophy
__Parkinson's Disease
__Difficulty Hearing
__Ringing in the Ears
__Eye Correction
__Double Vision
__Cataracts
__Other_____

Reproductive/Urinary
__Burning on Urination
__Nighttime Urination
__Blood in Urine
__Erectile Dysfunction
__Prostate Problems
__Abnormal Discharge
__Yeast Infection
__Bladder Leakage
__Pregnancy
__Current __Previous
__PMS
__Menopause
__Pelvic Inflammatory Disease
__Endometriosis
__Hysterectomy
__Fertility Concerns
__Other_____

Other
__Loss of Appetite
__Forgetfulness/Memory Loss
__Confusion
__Depression
__Anxiety
__Weight Loss/Weight Gain
__Fatigue
__Fever
__Loss of Hair
__Hot/Cold Intolerance
__Difficulty Concentrating
__Hearing Impaired
__Visually Impaired
__Eating Disorder
__Diabetes
__Fibromyalgia
__Post/Polio Syndrome
__Cancer
__Rheumatiod Arthritis
__Infectious Disease_____
_____

__Congenital/Acquired Disabilities
_____

__Other_____
_____

Height	Weight

Comments:_____

_____

_____

I acknowledge and agree that I am here to learn about nutrition and better health practices and that I will be offered information about food, supplements, herbs, or any other information deemed important by my health professional, to serve as a guide to improve my general health and well-being. I am aware that the information provided on this form will be used by Simply Nutrilistic in regards to my education, and that my rights concerning the privacy of said information is safeguarded. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purposes or treatment procedures. I am not, on this visit or any subsequent visit, an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

The services performed here are at all times restricted to the consultation on nutritional matters intended for the maintenance of the best state of natural health and do not involve the diagnosing, treatment, or prescribing of remedies for disease. I understand that I am responsible for all costs of care incurred, as determined by my health professional. Any fees for professional services will be immediately due and payable.

_____ _____

Patient or Guardian Signature Date