Confidential Client Information

Date:_____

Full Name _____ Nick Name _____

Address _____

Home Phone _____ Cell Phone _____

Email Address _____ Contact Preference: Phone Email Text

Gender _____ Age _____ Marital Status _____ Religious Preference_____

Occupation _____

Known Allergies_____

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 in the past? _____

Explain: _____

_____

What have you done/used to get relief? _____

_____

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

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

Nutritional

Current Vitamins/Herbs/Supplements and Dosage (please include the brand)

How many ounces of water per day?_____ What kind? _____

Other beverages consumed and amount _____

Do you use artificial sweeteners? ____ If yes, which ones? _____

How often and in what? _____

Do you eat breakfast? _____ If so, what? _____

Do you snack between meals? _____ If so, what? _____

Please indicate the servings of these you consume per week:

Fresh fruit _____ Raw vegetables _____ Fermented foods _____ Fast food _____ Meat _____

Eggs _____ Dairy _____ White flour _____ Whole grains _____ Soda _____ Coffee _____

Tea _____ Acoholic beverages _____ Tobacco products _____ Other _____

What type of foods do you crave? Salty Chocolate Sweets Breads Other _____

_____

What are your favorite foods?_____

What foods do you dislike the most? _____

_____

Why? _____

_____

What time do you eat your first meal? _____ Last meal? _____

What is your largest meal of the day? _____ Describe a typical "largest meal" _____

_____

Do you snack before bedtime or during the night? _____ If so, what time and on what? _____

_____

What is the first thing you do when you get up in the morning? _____

_____

Movement

Do you exercise/move/participate in fun sweaty activity? If so, what and how often? _____

_____

_____

Do you look forward to it? _____

How do you feel when you have finished? _____

Sleep

What time do you go to bed? _____ How long do you sleep? _____ Do you wake often? _____

If so, why and what times? _____

Do you feel rested when you wake for the day? _____ Do you have pain when you first get up? _____

If so, where? _____

Does it go away upon moving? _____

Eliminations

Do you have daily bowel eliminations? _____ If so, how many per day? _____ If no, please describe your elimination pattern _____

_____

Do you experience problems with urination? _____ If so, please explain? _____

_____

Have you noticed any unusual colors/smells? _____ If so, what? _____

_____

Medical History

Current/Recent Physicians

Name	Specialty	Last Seen

Current Medications and Dosage (Prescribed or OTC)

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

_____

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

_____

_____

Females

What was the date of your last menstrual period? _____ Is your menstrual cycle regular? _____

Is your cycle longer or shorter than 28 days? _____ Is your flow longer or shorter than 5 days? _____

Are you now, or in the near future planning to become pregnant? _____

Do you experience cramps or clotting? _____ Would you describe the color of your menses as more red, more purple, or more brown? _____ What symptoms do you experience before or during menstruation? _____

_____

Are you post-menopausal? _____ If yes, at what age did you enter menopause? _____

What were the characteristics of your menopausal experience? _____

_____

Do you currently use Hormone Replacement (HRT) or Hormonally-based contraception? _____

Social History

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

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? _____

Do you have any animals living in your house with you? _____ If so, what and how many?_____

_____

Do you have other animals or livestock? _____

Symptoms and Areas of Concern (check all that apply)

- [ ] Acne
- [ ] ADD/ADHD
- [ ] Adrenal Glands
- [ ] Allergies
- [ ] Alzheimer's Disease
- [ ] Anemia
- [ ] Anger
- [ ] Anxiety
- [ ] Appetite
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Bad Breath
- [ ] Bed Wetting
- [ ] Bell's Palsy
- [ ] Bites
- [ ] Bladder
- [ ] Blood Pressure - High
- [ ] Blood Pressure - Low
- [ ] Boils
- [ ] Bones
- [ ] Breathing
- [ ] Bronchitis
- [ ] Bruises
- [ ] Burns
- [ ] Cancer
- [ ] Candida
- [ ] Canker Sores
- [ ] Carpal Tunnel
- [ ] Cataracts
- [ ] Chest Congestion
- [ ] Chest Pain
- [ ] Cholesterol
- [ ] Circulation
- [ ] Cold - Common
- [ ] Cold - Temperature
- [ ] Colic
- [ ] Colon
- [ ] Constipation
- [ ] Cough
- [ ] Cravings
- [ ] Dandruff
- [ ] Depression
- [ ] Diabetes
- [ ] Diarrhea
- [ ] Digestion
- [ ] Dizzy Spells
- [ ] Ear Infection
- [ ] Ear Ringing
- [ ] Edema
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Eyesight
- [ ] Fatigue
- [ ] Fever
- [ ] Flu
- [ ] Gallstones
- [ ] Gangrene
- [ ] Gas
- [ ] Gout
- [ ] Gums
- [ ] Hair Issues
- [ ] Headache
- [ ] Heart Issues
- [ ] Heartburn
- [ ] Hemorrhoids
- [ ] Herpes
- [ ] Hiatal Hernia
- [ ] Hives
- [ ] Hormones
- [ ] Hyperactive
- [ ] Hypertension
- [ ] Hyperthyroidism
- [ ] Hypoglycemia
- [ ] Impotence
- [ ] Incontinence
- [ ] Indigestion
- [ ] Insomnia
- [ ] Joint Pain
- [ ] Kidney Issues
- [ ] Kidney Stones
- [ ] Laryngitis
- [ ] Leprosy
- [ ] Leukemia
- [ ] Liver
- [ ] Lung Issues
- [ ] Lupus
- [ ] Lymph Glands
- [ ] Menopause
- [ ] Menstrual Cramps
- [ ] Migraines
- [ ] Mononucleosis
- [ ] Mucous
- [ ] Nails
- [ ] Nausea
- [ ] Nervousness
- [ ] Nose Bleeds
- [ ] Parasites
- [ ] Parkinson's Disease
- [ ] Perspiration
- [ ] PMS
- [ ] Pneumonia
- [ ] Polyps
- [ ] Pregnancy
- [ ] Prostate
- [ ] Psoriasis
- [ ] Rash
- [ ] Reproductive
- [ ] Respiratory
- [ ] Rheumatism
- [ ] Ring worm
- [ ] Seizures
- [ ] Shingles
- [ ] Sinus
- [ ] Skin Issues
- [ ] Snoring
- [ ] Sore Throat
- [ ] Stomach
- [ ] Stress
- [ ] Stroke
- [ ] Sty
- [ ] Teething
- [ ] Tennis Elbow
- [ ] Tonsillitis
- [ ] Tumors
- [ ] Ulcers
- [ ] Urinary Infections
- [ ] Varicose Veins
- [ ] Vertigo
- [ ] Weight - Overweight
- [ ] Weight - Underweight
- [ ] Yeast Infections
- [ ] OTHER:

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.

Signature _____ Date _____

Pastoral Medical Association
Promoting Lifelong Health and Well-Being