Confidential Client Information

Date:_____

Full Name _____

Address_____

Home Phone _____ Cell Phone _____

Email Address _____

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? _____

Please 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

How many ounces of water per day?_____ Type (circle): Distilled R.O. Filtered City Well Spring

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 _____

Alcoholic beverages _____ Tobacco products _____ Other _____

What type of foods do you crave? Salty Chocolate Sweets Breads Other (Please List)

_____

_____

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? _____
What electronics or smart devices are in the room where you sleep?_____
_____
Is your house meter near your bedroom? _____
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

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._____
_____
_____

Current Physicians:

Name	Specialty	Last Seen

Current Medications (Rx and OTC):

Current Supplements (include brand):

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:

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____
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? _____

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 LLC 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