Holistic Wellness Questionnaire

Congratulations on taking the time to invest in your health and wellbeing.

Through diet and lifestyle changes specific to your needs, we will focus on bringing your body as a whole back into harmony. As a result, your plan is created based on your health status and history with a focus on promoting prevention, healing and optimal wellness.

All the information gathered is completely confidential and will not be shared with any third parties.

Client Information

Name:________________________________

Date of Birth: ___ mm __ dd ____ yyyy

Email:________________________________

Home # ( )_____________ Cell # ( )_____________

Marital Status__________________________

Children? If yes, How Many? ____________________

Referred by:___________________________

Blood Type: A B AB O ____________________

Weight: __________ Height: ___________

Occupation ____________________

Please Enter Your Address:

No. & Street __________________________

Apt. #, Unit #, Address Line 2: ___________________

City, Town: __________________________

Province, State ___________________

Postal Code: __________________________

Country ___________________

Main Health Concerns

Please list your main nutrition/health concerns.
(Digestion, skin health, migraine/headaches, weight loss/gain, high cholesterol, eating for better health, cancer, diabetes, hormonal imbalances, sports nutrition, etc.)

Is there any anything specific you would like to cover during this session?

Personal Health History

List any and all diagnosis you have received for any health concerns recently, or in the past, include childhood.

Are you seeing any other healthcare practitioners? Please check all that apply.

☐ Medical Doctor	☐Dentist	☐ Naturopath
☐ Acupuncturist	☐Psychiatrist	☐ Chiropractor
☐ Massage therapist	☐Osteopath	☐ Herbalist
☐ Homeopathic Doctor	☐Chinese Medicine	

Surgeries (include dates, reason for surgery, and if general anesthetic was used):

List all of your current medications.

Medications	**Duration**	**Reason/Condition**
___________________________	__________	________________
___________________________	__________	________________
___________________________	__________	________________
___________________________	__________	________________
___________________________	__________	________________
___________________________	__________	________________

How many times you have been on antibiotics in the past 10 years, if any. _____________

List all your current supplements (vitamins, minerals, herbs).

Natural Health Product	**Dose**	**Duration**	**Reason/Condition**
________________________	________	________	________________
________________________	________	________	________________
________________________	________	________	________________
________________________	________	________	________________
________________________	________	________	________________

Please check any symptoms you are currently experiencing				
☐ Headaches	☐ Ridges on nails	☐ Brittle nails	☐ Red bumps on back of arms	
☐ White spots on nails	☐ Coated tongue	☐ Oily skin	☐ Runny nose	
☐ Itchy skin	☐ Skin rash	☐ Dry Skin		
☐ Itchy eyes	☐ Dry scalp	☐ Cold Hands /feet		
	☐ Hay fever			

Hours of sleep per night: __3-5 __6-7 __8-10+

Do you wake up feeling rested? ___Yes ___No

Do you wake throughout the night? ___Yes ___No

Do you Exercise? ___Yes ___No

If yes, indicate what you do and how often:

Indicate your level of energy: 1 being low, 10 being high on an average day. ___________

Does your energy change throughout the day? (write: low, normal, or high in the corresponding time slots)

____________	____________	____________	____________	____________	____________
6am – 9am	9am –noon	noon-3pm	3pm	4pm-6pm	6pm to bedtime

Do you have any known allergies or suspected food intolerances. List all.

Check all digestive concerns you experience either now or have in the past.

☐ Bloating	☐ Gas	☐ Cramping
☐ Constipation	☐ Loose stools	☐ Diarrhea
☐ Heartburn	☐ Indigestion	

How many bowel movements do you have a day? ___0 ___1 ___2+

Do you fluctuate between constipation and diarrhea? ____Yes ___No

Dental Health History:

Amalgam/silver fillings: How many (current)?_________ (removed)?_____

# of Root canals?________ # of Teeth removed?______Dental Diagnosis (Ex: gingivitis)__________________

Crowns or other metals (braces, retainers, partials?)_____________________________

Family Health History:

List any health issues (past or present) of parents and siblings

Dietary Health Overview

Do you have any cravings? If so, list all.

List the top 5 Foods you eat most often:

1_________________________ 3_________________________ 5_________________________
2_________________________ 4_________________________

Do you have any dietary restrictions?
For example: no red meat, vegan, vegetarian,
no milk, etc. Please be very specific.

Are there any foods you are not willing to give up?

Is there any particular food you feel addicted to?

Do you consume alcohol?
___Yes ___No

If yes, how much and how often:

Do you smoke?
___Yes ___No

If yes, how much and how often:

Do you use recreation drugs?
___Yes ___No

If yes, how much and how often:

How many glasses of water do you drink in a day? ____________

What is the source of your water?

- ☐ Filtered
- ☐ Tap
- ☐ Reverse osmosis
- ☐ Bottled

Do you drink caffeinated beverages?
___Yes ___No

If so, how many per day/week?
_________per day _________per week

Do you drink carbonated beverages?
___Yes ___No

If so, how many per day/week?
_________per day _________per week

Do you drink any diet drinks?
___Yes ___No

How many fruits do you eat per day? _________
1 serving = 1 apple

How many vegetables do you eat per day? ___
1 serving = 1 cup broccoli

Are the fruits and vegetables organic? ___ Yes ___No

Do you bring your lunch to work or eat out**?**____

Do you enjoy cooking and preparing food?____

Your Sexual Health

Do you have a healthy sex drive?
If not, when was the last time you can
remember having one?

At what age did you reach puberty?

Do you have any hormonal issues that
you are aware of? If so, please explain.

Women Only – Your Reproductive Health

Please check any symptoms of PMS you experience

- ☐ Cramping
- ☐ Bloating
- ☐ Headaches
- ☐ Change in mood
- ☐ Breast tenderness
- ☐ Irritability

Please check any symptoms of menopause you experience

- ☐ Hot flashes
- ☐ Cravings
- ☐ Headaches
- ☐ Changes in mood
- ☐ Weight gain
- ☐ Irritability

Do you have a regular Menstrual Cycle?___Yes ___No Date of last Cycle: __________ Duration: _________

Do you experience Yeast &/or Bladder infections? ___Yes ___No

Are you on the Birth Control Pill? ___Yes ___No When did you start?______ When did you stop? __________

Do you experience emotional upset at the same time each month?
(depression, anxiety, nervousness, excitability, extreme emotions)

Men Only

Frequent Urination? ___Yes ___No   How many times do you go through the night?___________________

Prostrate Enlargement? ___Yes ___No

Concerns with Fertility? ___Yes ___No

Concerns with Erectile Function? ___Yes ___No

Your emotional Health

Has there been any significant emotional Trauma
in your life? Divorce, separation, Family problems,
death of someone close, abuse, etc.
Please describe.

Do you tend to eat MORE or LESS when stressed? _________________________

Indicate your stress level: (1 being low, 10 being high on an average day) __________

What do you do to cope with stress?

Chemical Stressors: (circle any that apply to you and indicate if and when you quit)

- Smoking
- 2nd Hand Smoke
- Vaccinations
- OTC Drugs
- Alcohol
- Caffeine
- Refined Sugar
- Artificial Sweeteners
- Occupational Toxins
- Prescription Meds
- Perfume
- Environmental Toxins
- Chemotherapy
- Pesticides
- Hairspray
- Antiperspirant
- Aluminum Cookware
- Chemicals associated with home renovations (ie. Paint, solvents, new carpets, etc.)

Mental/Emotional Stressors: (circle any that apply to you)

- Children/Dependents
- Divorce/Separation
- Loss of loved one
- Change in Residence
- Change in Career
- Change in Lifestyle
- Depression
- Work Commuting
- School Fast-paced-life
- Internalized feelings
- Quick Temper
- Perfectionist
- Procrastinator
- Financial
- Health/Illness
- Care-giving
- Anxiety

Nutritional Expectations

What are you expecting from your nutritional program?

How do you think your nutrition program will affect your daily life?

Have you tried any nutrition programs or diets in the past? Were you successful?

How would you rate your ability in the following areas:
(Rating Scale: poor, needs improvement, good or excellent)

- Scheduling/Planning of Meals____
- The healthiest ways of preparing foods____________________________________
- Level of commitment to a program:_______________________________________
- Balancing carbs, fat, protein ratios____

Please include anything else you want to cover in your nutrition session:

Thank you for taking the time to complete this questionnaire.
I look forward to helping you as you achieve a whole, healthy you!

*It is helpful to have ample time to review your information. If possible, please send your paperwork at least one day prior to your scheduled appointment You can send it by scanning and emailing it to deanne@thehealthyroot.com.