Client Health Questionnaire

FOR WOMEN ONLY

Yes No

☐ ☐ Are you pregnant?

☐ ☐ Are your periods regular?

☐ ☐ Do you take birth control pills?

Yes No

☐ ☐ Is there a chance you might be pregnant?

☐ ☐ Do you suffer from PMS?

☐ ☐ Do you take Hormone supplements?

FOR MEN ONLY

Yes No

☐ ☐ Do you have difficulties urinating?

☐ ☐ Are you experiencing ED difficulties?

Yes No

☐ ☐ Do you take hormone supplements?

Date of last colonoscopy: _____

Please explain all yes answers below:

_____

DAILY HABITS

What is a typical:

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Daily Water Consumption: _____

Beverages: _____

Alcohol: _____ What and How often: _____ Rec.Drugs _____

Yes No

☐ ☐ Do you exercise? Describe: _____

_____

Please describe your dietary intake: (example; vegan, vegetarian, food combining, non-vegetarian-beef, pork, poultry, seafood, home cooking, home/dining out, fast food, etc.)

_____

_____

On a scale from 1 5, (with one being low and five being very high) what best describes your usual daily stress level? (circle one) 1 2 3 4 5

Are circumstances in your life increasing your usual stress level? (you may share if you wish)

_____

_____

Yes No

☐ ☐ Are you interested in learning more about diet and lifestyle changes?

_____

_____