

CLIENT QUESTIONNAIRE

NAME _____ DATE _____
ADDRESS _____ TOWN _____
PROVINCE & POSTAL CODE _____ HOME PHONE # _____
WORK PHONE # _____ BIRTHDATE _____
APPROXIMATE HEIGHT _____ APPROXIMATE WEIGHT _____

Briefly explanation of why you have consulted me: _____

PRIVACY POLICY

Please answer all questions honestly. The information taken will be kept strictly confidential.

Please place a check mark if your answer is "yes" and leave the space blank if your answer is "no."

1. Frequent Colds Lung Congestion Sinus Congestion Cough Shortness of Breath
 Asthma . How long have you had these symptoms? _____ Do you smoke?
2. Female: Pregnant Are or have you been on birth control pills Low Libido (sex drive)
 PMS Difficult Periods, and if yes, please describe _____. Going
through Menopause with symptoms (hot flashes, night sweats, mood swings, etc;) If so, explain

3. Male: Prostate Problems Excessive Urination with burning sensation with urination
 Premature Ejaculation or Impotence Low libido (sex drive) Difficulty in getting or
maintaining an erection.
4. Blood Pressure Problems (high or low) Arteriosclerosis Family History of heart disease
 Specific Heart Conditions, if so, explain _____
5. Discharge other than urine when urinating Pain in lower back or waist Fluid Retention
(bloating) Urine can be cloudy or bloody Ever had Kidney Stones? If so, when? _____
6. History of hepatitis or liver disorder Gall bladder problems Do you drink heavily?
 Do you eat a lot of fatty, rich foods? Consistent gas and bloating from most foods
 Fat/greasy foods cause nausea, headaches Bad Breath/bad taste in mouth Onions,
cabbage, radishes, and/or cucumbers cause gas, bloating, and distress Stools appear yellow or
clay colored Been on drugs (legal or illegal) Been exposed to industrial chemicals
7. Do you have severe pain? If so, where? _____
 Recent physical injury Recent operation Recent fracture, sprain, or wound
8. Allergies, including to food. If so, to which _____. Hay fever
 Runny nose or raw throat Dry, irritable cough Cough with phlegm Post-nasal drip
9. Recessed eyes Low blood pressure Burning sensation after bowel movement
 Bumps on the tongue or roof of mouth Sensitivity of teeth to vinegar and acidic fruits
 Migraine headaches Insomnia Water retention Rheumatoid arthritis Dry, hard
stools
10. Sore muscles Creaking joints Bursitis Protruding eyes Hypertension Edema
 Night cramps Chronic Indigestion Night coughs

11. Weakness Lethargy Dizziness Headaches Memory problems Food cravings
 Allergies Blood sugar disorders Persistent high blood pressure Rapid pulse
 Unusual craving for salt More than usual neck, head, shoulder tension
12. Depression Disoriented perceptions of space and time Inability to concentrate and/or
communicate properly Loss of bladder/bowel control Memory loss Personality changes
 Severe mood swings
13. Diarrhea, without apparent cause (flu) Mucous shreds in stools Painful, hard bowel
movements Pencil-like bowel movements Alternating constipation & diarrhea
 Hemorrhoids or rectal fissures
14. Arms and legs “go to sleep” Cramps in hand when writing Sharp diagonal crease in
earlobe Tingling sensation in lips or fingers Short walk causes cramping or pains in legs
 Failing Memory High blood pressure Chest pain after physical exertion or emotional
stress Varicose veins or ulceration of veins Problems with circulation in extremities
15. Indigestion or sourness 2-3 hours after meals Abdominal Bloating/distension Excessive
gas, belching or burping after meals Heavy, tired feeling after eating Constipation
 Burning sensation in stomach Loss of former taste or craving for meat
16. History of parasites or worms Head lice Traveled to an undeveloped country Teeth
grinding Sleep disturbances Rectal itching (especially at night)
17. Immune problems Chronic fatigue Frequent colds and/or infections
18. History of cancer in family Have active cancer right now Cancer is in remission
 Interested in cancer prevention for myself
19. Insomnia or sleeplessness Insomnia due to stress Wake up a lot during the night
20. Stressed out Nervous Mentally exhausted Dealing with deep emotional issues now
21. Dry skin Eczema Psoriasis Acne Dandruff Rashes Dermatitis
22. Weakness Fatigue Coldness of extremities Depression Dizziness Pale and
brittle nails Pale lips and eye lids Loss of appetite Constipation Headaches
23. Hangnails White bands across nails Dry/brittle nails Horizontal or vertical ridges
 “Spoon” shaped nails White spots on nails Fungus (yellowing) under and around nails
24. Upper abdominal swelling and distension, and/or pain described as burning or stabbing
 Excessive gas Abnormal fatty stools Feel cold and sweaty Breath smells sweet or
of acetone Moody with marked ups and downs Constant intense thirst Shakiness
25. Protruding or bulging eyes Dark circles under the eyes Yellowing of the whites of the
eyes Difference in size of pupils Periodic blurring of vision
26. Diarrhea Weight loss Nutritional deficiencies Abdominal Swelling Pale or light
yellow colored foul-smelling stools Joint and/or bone pain
27. Fatigue Intolerance to cold Slow heart rate Lowered body temperature Weight
gain, fail to lose on diets Constipation Depression Difficulty concentrating
 Yellowish tint to skin on hands and feet Heart seems to miss beats or turn “flip flops”
28. Nervousness Irritability Constant feeling of being hot Increased perspiration
 Insomnia and fatigue Hair and weight loss Increased frequency of bowel movements
 Separation of the nails from the nail bed Less frequent menstruation and decreased
menstrual flow Hand tremors Intolerance to heat Rapid heart beat Protruding eyes

29. ___ Fatigue/dizziness ___ Lightheadedness ___ Headache ___ Irritability ___ Fainting spells
 ___ Depression ___ Anxiety ___ Sudden strong cravings for sweets, coffee, or alcohol ___ Night
 sweats ___ Weakness in legs ___ Swollen feet ___ Constant hunger (and/or get hungry soon after
 eating) ___ Insomnia ___ Irritable if late for a meal or miss a meal ___ Wake up in middle of the
 night and can not go back to sleep ___ Cold hands and feet
30. ___ Repeated use of antibiotics or birth control pills ___ Diarrhea or constipation ___ Abdominal
 pain ___ Bad breath ___ Persistent heartburn ___ Congestion and/or nagging cough ___ Craving for
 sugar, bread, and/or alcohol ___ Tingling sensations ___ Bladder Infections ___ Coated and/or sore
 tongue ___ Feelings of being “drained” ___ Yeast infections, athlete's foot, or jock itch
31. ___ Constipation and/or diarrhea (often alternating) ___ Abdominal pain ___ Mucous in stools
 ___ Nausea ___ Flatulence ___ Bloating ___ Intolerances to certain foods
32. ___ Behavioral changes ___ Depression ___ Irritability ___ Hyperactivity ___ Metallic taste in
 mouth ___ Arthritis ___ Dermatitis ___ Gum disease ___ Hair loss ___ Memory loss ___ Muscle
 weakness ___ Excessive salivation

Nutritional Information

Circle the appropriate answer.

Beef/Pork/Lamb	Everyday	Often	Sometimes	Rarely	Never
Fish	Everyday	Often	Sometimes	Rarely	Never
Chicken	Everyday	Often	Sometimes	Rarely	Never
Fresh Vegetables	Everyday	Often	Sometimes	Rarely	Never
Fresh Fruit/Juice	Everyday	Often	Sometimes	Rarely	Never
Fast Foods	Everyday	Often	Sometimes	Rarely	Never
Pop, including diet	Everyday	Often	Sometimes	Rarely	Never
Cookies, pastries, cakes	Everyday	Often	Sometimes	Rarely	Never
Canned fruits/vegetables	Everyday	Often	Sometimes	Rarely	Never
White sugar, flour, rice	Everyday	Often	Sometimes	Rarely	Never
Whole grains	Everyday	Often	Sometimes	Rarely	Never
Skim milk or low fat milk/cheese	Everyday	Often	Sometimes	Rarely	Never
Caffeinated drinks	Everyday	Often	Sometimes	Rarely	Never
Raw seeds and/or nuts	Everyday	Often	Sometimes	Rarely	Never
Olive oil	Everyday	Often	Sometimes	Rarely	Never
White flour products	Everyday	Often	Sometimes	Rarely	Never
Deep fried foods	Everyday	Often	Sometimes	Rarely	Never
Packaged snack foods	Everyday	Often	Sometimes	Rarely	Never
Alcoholic beverages	Everyday	Often	Sometimes	Rarely	Never
Beans, lentils, or peas	Everyday	Often	Sometimes	Rarely	Never
Eggs	Everyday	Often	Sometimes	Rarely	Never
Butter	Everyday	Often	Sometimes	Rarely	Never
Vegetable oil/Margarine	Everyday	Often	Sometimes	Rarely	Never
Yogurt, kefir, miso, tempeh	Everyday	Often	Sometimes	Rarely	Never
Soybeans, Soy products	Everyday	Often	Sometimes	Rarely	Never

Are you currently, or have you in the past taken any prescription drugs? If so, which? _____

Are you taking any vitamins or food supplements and, if so, which? _____

Have you been diagnosed with a chronic disease and, if so, which? _____

Are you currently under a physician's care for some particular condition?

Do you have any amalgam dental fillings, and if so, how many? _____

Are you exposed to chemicals in your workplace? _____

Do you experience any symptoms not described in this questionnaire? If so, please describe: _____

Do you exercise? If so, what type and how often? _____

Is there a history of any type of illness or physical problem in your family? If yes, please describe:

To the best of my knowledge, I have answered everything truthfully.

Signature

Date

(Check: 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or often occurring, or leave blank if the symptom/statement does not apply.)

<i>Please complete this section:</i>			1	2	3	4	5	6	7	8	9	10		
	SUBTOTALS													
41	Excessive mucous	R I G H T												
42	Short of breath climbing stairs													
43	Tingling in lips, fingers, arms, legs													
44	Chest pains													
45	Very rapid or slow heart beat													
46	Painful, hard or thin bowel movements		S I D E											
47	Alternating constipation/diarrhea													
48	Recurrent bladder infections													
49	Female: menopause, hot flashes													
50	Female: PMS													
51	Difficult urination	F O R												
52	Swollen glands, puffy throat													
53	Lower abdominal pain													
54	Frequent need to urinate													
55	Joint pain			O F F I C E										
56	Sinus inflammation/discharge													
57	Arthritis													
58	Sudden weight gain/loss													
59	Headaches/migraines													
60	Female: Taking birth control pills		U S E											
61	Lower back pains													
62	Dry, flaky skin													
63	Drink less than 6 gasses of fluids/day													
64	Water retention	O N L Y												
65	Low sex drive													
66	Feeling heavy/bloated after meals													
67	Chronic cough													
TOTAL SCORES														

-----FOR OFFICE USE ONLY-----

1	Digestive	
2	Intestinal	
3	Circulatory/Cardiovascular	
4	Nervous	
5	Immune/Lymphatic	
6	Respiratory	
7	Urinary	
8	Glandular/Endocrine	
9	Structural	
10	Reproductive	

COMMENTS:

Nutrition Log

Day 1

	Meal	Protein	Carbs	Fat
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				
Total				

Supplements:
Medications:

Day 2

	Meal	Protein	Carbs	Fat
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				
Total				

Supplements:
Medications:

Day 3

	Meal	Protein	Carbs	Fat
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				
Total				

Supplements:
Medications:

Name: _____

Date: _____