***WELCOME!*** *New Client Questionnaire* Date: _____

## Personal Information

Name _____ Please call me _____

Address _____ City _____ State/Zip _____

SSN _____-_____-_____ ❑ Male ❑ Female Date of Birth _____

Relationship Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated
❑ Engaged ❑ Long-term relationship

Race: ❑ Caucasian ❑ African American ❑ Hispanic ❑ Native American ❑ Asian
❑ Middle Eastern ❑ Pacific Islander

Home phone _____ Work _____ Cell _____

Email _____ Contact preference _____

Occupation _____

Employer _____

How many hours do you work each week? _____

If retired, former occupation(s) _____

How were you referred? _____

## Medical History

Do you have a primary care physician? ❑ Yes ❑ No

Doctor's name _____ Phone # _____

Office address _____

Are you currently taking any prescription medications? ❑ Yes ❑ No
If yes, please list medication and dosage:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

**Medical History, continued**

Your height _____(ft.) _____ (inches) Weight _____ lbs.

Blood type: ❑ Type A ❑ Type B ❑ Type AB ❑ Type O ❑ Don't know

**Do you take laxatives?** ❑ Yes ❑ No

If yes, circle the one(s) you take: Metamucil Flaxseed Miralax Citrucel Senna Rhubarb root Ducolax Other:_____

How often do you take laxatives? ❑ Daily ❑ Weekly ❑ Less than twice a month

**Do you currently take over-the-counter (OTC) antacids?** ❑ Yes ❑ No

If yes, circle the one(s) you take: Prilosec Prevacid Nexium Zantac Tagamet Pepcid Maalox Mylanta Roliads Tums Other:_____

How often do you use OTC antacids? ❑ Daily ❑ Weekly ❑ Less than twice a month

**Do you currently take OTC pain relievers (Advil, Tylenol, Aspirin, etc)?** ❑ Yes ❑ No

If yes, how often? ❑ Daily ❑ Bedtime ❑ Weekly ❑ Less than twice a month

Have you ever been hospitalized? ❑ Yes ❑ No

If yes, please list the reason(s):

_____

_____

When you were born, how were you delivered?

❑ Vaginal birth ❑ Cesarean birth ❑ Don't know

Where you breastfed?

❑ Yes ❑ No ❑ Don't know

If yes, how long?

❑ 0-3 months ❑ 3-6 months ❑ 6-12 months ❑ 12+ months ❑ Don't know

If you are 50-75 years old, have you received appropriate screening for colorectal cancer, such as colonoscopy, fecal blood testing or sigmoidoscopy? ❑ Yes ❑ No

If yes, results were: ❑ Normal ❑ Positive for benign polyps ❑ Positive for cancerous polyps

**Please check all that apply to you**

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilespy
- ❑ Emphysema
- ❑ Eyes, ears, nose and throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Genetic disorders
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Kidney/bladder disease
- ❑ Learning disabilities
- ❑ Liver/gallbladder disease
- ❑ Mental illness
- ❑ Migraine headaches
- ❑ Neurological problems
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sinus problems
- ❑ Skin problems/eczema
- ❑ Stroke
- ❑ Thyroid issues
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Urinary tract infections
- ❑ Vericose veins
- ❑ Gastroesophageal reflux disease
- ❑ Inflammatory bowel syndrome
- ❑ Irritable bowel syndrome

**Family Health History (Parents & Siblings)**

- ❑ Arthritis
- ❑ Asthema
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Digestive disorders
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Heart disease
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide
- ❑ Other

_____

_____

_____

## Health Habits

Tobacco ❑ Yes ❑ No Cigarettes/day _____ Cigars/day _____

Are you exposed to 2nd hand smoke? ❑ Yes ❑ No

Are you exposed to toxic substances at work? ❑ Yes ❑ No

At home? ❑ Yes ❑ No

If yes, please describe: _____

_____

Wine ❑ Yes ❑ No Glasses / day or week _____

Liquor ❑ Yes ❑ No Ounces / day or week _____

Beer ❑ Yes ❑ No Glasses / day or week _____

Marijuana ❑ Yes ❑ No Times / week or month_____

## Nutrition History

Do you have any food allergies, restrictions or sensitivities? _____

_____

Do you follow a particular diet style?

❑ Vegetarian ❑ Vegan ❑ Gluten-free ❑ Kosher ❑ Low carbohydrate

❑ Paleo ❑ Low fat ❑ Belief-based ❑ Other _____

Have you experienced significant weight change in the past 3 months? ❑ Yes ❑ No

Has your weight been stable over your lifetime? ❑ Yes ❑ No

If yes, please describe the change. _____

_____

Does your current diet differ from your diet in the past? ❑ Yes ❑ No

If yes, please describe: _____

_____

_____

Describe your daily energy levels: _____

_____

Do you crave any of the following?

❑ Sugar ❑ Meat ❑ Salt ❑ Chocolate ❑ Bread ❑ Fried foods

❑ Desserts ❑ Fat ❑ Caffeine ❑ Alcohol ❑ Other _____

When do cravings occur (a.m. / p.m. / between meals, etc.) _____

_____

Do you drink soda? ❑ Yes ❑ No If yes, diet or regular? _____

How often? ❑ Daily ❑ Weekly ❑ Less than twice a month

Do you take any nutritional supplements? ❑ Yes ❑ No If yes, please list type and dose:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

## Women Health: Menstrual Cycle

Age of 1st menstruation: _____ Days between cycles: _____ Avg. days you bleed: _____

Could you be pregnant? ❑ Yes ❑ No Pregnancies: _____ Miscarriages: _____

Date of last cycle: _____ Type of contraception:_____

## Women's Health Continued

Check if you have had any of these condition:

❑ PMS ❑ Pain between cycles ❑ Ovarian cysts ❑ Irregular periods ❑ D & C

❑ Endometriosis ❑ Infertility ❑ Yeast infections ❑ STD ❑ Fibrocystic breasts

❑ Loss of libido ❑ Menopause ❑ Surgical menopause ❑ Hot flashes

❑ Breast cancer ❑ Pain during intercourse ❑ Cervical dysplasia

## Men's Health

Please check all that pertain:

❑ Frequent urination ❑ Difficulty urinating ❑ Infertility ❑ STD ❑ Loss of libido

❑ Difficulty with erection ❑ Prostate enlargement ❑ Prostate cancer

## Bowel Habits

How frequently do you have a bowel movement? ❑ 2-3 times/day ❑ once a day

❑ Every other day ❑ Less than three times/week

Consistency: ❑ Smooth & soft ❑ Hard & lumpy ❑ Loose & soft

❑ Watery ❑ Separate, hard lumps

## Lifestyle

Do you have a regular bedtime? ❑ Yes ❑ No

How many hours do you sleep? _____ Do you wake up during the night? ❑ Yes ❑ No

If yes, do you find it difficult to go back to sleep? ❑ Yes ❑ No ❑ Sometimes

Do you do aerobic exercise? ❑ Yes ❑ No Times/Wk _____ Min/Session _____

Do you do strengthening exercise? ❑ Yes ❑ No Times/Wk _____ Min/Session _____

How do you feel about your weight? _____

_____

How do you feel about your fitness level? _____

_____

How would you rate your stress level? ❑ Extreme ❑ High ❑ Manageable ❑ Low

Do you engage in any stress reducing activities? ❑ Yoga ❑ Tai Chi ❑ Meditation

❑ Deep breathing ❑ Volunteer work ❑ Other: _____

Have you or your family recently experienced any major life changes? _____

_____

Hobbies / Leisure Activities: _____

_____

## You and Food

How often do you eat out (indicate # of times and circle week or month)

Breakfast _____ times per week / month

Lunch _____ times per week / month

Dinner _____ times per week / month

How often do you typically grocery shop? _____ times per week / month

Where do you normally grocery shop?_____

Do you purchase organic produce and/or meat and poultry? ❑ Yes ❑ No

If no, check all that apply: ❑ Not available where I shop ❑ Too expensive

❑ No difference between conventional and organic ❑ Other:_____

When preparing meals at home, are you: ❑ A planner ❑ Spontaneous ❑ It depends

Do you like to cook? ❑ Yes! ❑ When I have time ❑ Indifferent ❑ No

How often do you eat breakfast ❑ Everyday ❑ Sometimes ❑ Weekends only

Which describes the majority of your meal times (check all that apply):

❑ At the table with family/friends ❑ Working ❑ Surfing the web ❑ Watching TV

❑ In the car ❑ Alone ❑ Other _____

When you were a child, did your family often eat meals together? ❑ Yes ❑ No

## Nutrition and Health Goals

List three areas where you have specific concerns or would like to make changes.

1. _____

2. _____

3. _____

Have you tried to make any of these changes in the past? ❑ Yes ❑ No

If yes, what was your experience with these efforts? _____

_____

_____

On a scale of 1 to 10 (1 is low, 10 is high), how would you rate your willingness to consider making any changes to your diet and/or fitness level at this point in your life?

1 2 3 4 5 6 7 8 9 10

*Would you like to subscribe to the Primal Plate Wellness blog? ❑ Yes ❑ No*