JENNIFER WHITNEY
Certified Holistic Nutritionist
Certified GAPS Practitioner
Certified Laser Therapist

New Client
Health Questionnaire

Name:_____ Date:_____
Address:_____
City:_____ State:_____ Zip:_____
Primary Phone:_____ Secondary Phone:_____
Email:_____
Age:_____ Height:_____ Weight:_____ D.O.B.:_____
Occupation:_____
Referred by:_____ Marital Status:_____

Family History
Father -- Alive/Deceased Mother – Alive/Deceased
Do you have any children?_____ What are their ages:_____

Circle illnesses which have occurred in any of your blood relatives (Father, mother, siblings):
Diabetes Cancer Bleeding Tendency Kidney Disease Tuberculosis Obesity Heart Disease High Blood Pressure
Nerve Disorders Allergies Alcoholism Mental Illness Stroke HIV/AIDS Auto Immune Disorders
Other:_____

Circle illnesses or conditions you have or have had:
Diabetes Glaucoma Heart Trouble High Blood Pressure Thyroid Condition Vein Trouble Cancer Asthma
Jaundice STD Bleeding Tendencies Tuberculosis Mumps Pneumonia Allergies Kidney Disease
Rheumatic Fever Nervous Disorders Measles Chicken Pox HIV/AIDS Meningitis Autoimmune Disorders
Mononucleosis High Fevers Hepatitis Polio Gallbladder Trouble Bladder Infections Candida
Kidney Stones Parasites Other:_____

List the date of your last dental exam:_____

Please list the date of your last physical exam:_____

WOMEN ONLY:
Do you have a period every month? ____ No ____ Yes
Are your periods heavy, painful or irregular? ____ No ____ Yes
Are you pregnant?_____ How many months?_____

Are you currently receiving care from a:

_____ Chiropractor	_____ Acupuncturist	_____ Medical	_____ Dental
_____ Naturopath	_____ Physical Therapist	_____ Massage Therapist	_____ Nutritionist

Do you have any type of allergies? ____ No ____ Yes Do you know specifically what you are allergic to?
_____

List your reason(s) for coming in today:
_____

List medication and/or supplements you are currently taking: _____
_____

How often do you have a bowel movement? _____
Do you tend towards: _____ Constipation _____ Diarrhea _____ Neither
Do you have any of the following in your stool? _____ Undigested food _____ Mucous _____ Blood
Does it hurt when you have a bowel movement? _____ Yes _____ No

Do you drink alcohol? _____ Yes _____ No Number of drinks per week: _____

Do you smoke cigarettes? _____ Yes _____ No Amount per day: _____

Do you use recreational drugs/medications? _____ Yes _____ No Type: _____

Do you exercise? _____ Yes _____ No _____ Indoors _____ Outdoors
Activities: _____ Amount per week? _____

How well do you sleep? _____

On a scale of 1 to 10, rate your current level of stress (10=Very High) _____
What activities do you engage in to counterbalance stress in your life? _____
_____

On a scale of 1-10 rate your overall energy level (1 very little energy, 5 average & 10 too much energy): _____

On a scale of 1-10, rate how healthy you feel right now (10=Very High) _____

On a scale of 1-10, rate how motivated you feel today? (10=Very Motivated) _____

Is your family aware that you are starting this program? ____ No ____ Yes If so, who? _____
Will your family support your decision and help you with your goals? ____ No ____ Yes

How would you describe your relationship to food? Do you like to eat? ____ No ____ Yes
How many times a day do you eat? _____
Do you find that you eat or crave certain foods more when you feel stressed or emotional? ____ No ____ Yes
If yes, what foods do you crave? _____
How many times a week do you eat out? _____
How many times a week do you cook? _____ How many people do you cook for? _____
How much time do you have to prepare meals? _____ Is it different for you on the weekend? ____ No ____ Yes
What are some of your favorite foods? _____
What are some common snacks that you eat? _____
Where do you do most of your grocery shopping? _____

Please take a moment to list what you have eaten in the last 24 hours.

TIME	BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SNACK

Thank you for coming in today and filling out the intake form. We have asked for a lot of personal information from you today. This helps us to get a larger picture of what is going on. Though we may not address everything today, this will give us a starting point to help you reach your health goals.

I am not a medical doctor and cannot diagnose or treat. I can offer suggestions and help to guide you on your journey to greater health.

The suggestions I will offer today may seem small but this is just the beginning of your journey. It is important to keep your goals small and manageable in the beginning. You will be quite surprised how minor changes can make a huge difference in how you feel.

_____

Client Signature

_____

Date