Plant-Based Nutrition and Lifestyle, Inc.

Client Assessment Questionnaire

Please answer all questions honestly and with the intent of providing as thorough a picture as possible of your health history. This form is confidential. This information cannot and will not be given to anyone outside this office without your written permission!

Successful diet and health assessment are only possible when the practitioner has a understanding of the patient physically, mentally, and emotionally. However, if any of these questions are difficult to answer or talk about, please let the practitioner know.

The nature of your responses to the following questions will go a long way in assisting my understanding of you. Your time, thoughtfulness and honesty are greatly appreciated!

General Information

Date: / /

Name:
Mailing Address:
Email:
Phone (h):
(c):

Personal Information

Age:	Height:	Weight:	Marital Status:
Gender: M F			
Occupation:			
Emergency Contact:		Relationship:	Phone (h):
			Phone (c):

What level of change to your living habits are you willing to make to improve your health and address underlying causes of your signs and symptoms? (0% being no commitment, 100% complete commitment)

0% 10 20 30 40 50 60 70 80 90 100%

What goals do you have for your initial consultation?

_____

_____

_____

Client Assessment Questionnaire

List your major health concerns in order of importance: Duration: Severity (1 to 10)

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

General Medical

Indicate whether you have had blood relatives with any of the following problems:

Cancer: yes no High Blood Pressure: yes no Diabetes: yes no
Osteoporosis: yes no Heart Disease: yes no High Cholesterol: yes no
Thyroid disorder: yes no Other: _____

List any known food allergies or intolerances:

_____
_____

Outpatient Procedures / Hospitalizations, surgeries/ special diagnostic studies:

Type (of surgery/study)	Date	Reason for procedure/admission	Outcome / Results

Recent physical exam: Date: _____ Results: _____
Recent blood work/ urine test: Date: _____ Results: _____
Blood Pressure: _____ Total Cholesterol: _____
Blood Type: _____

Major Illnesses/emotional or physical trauma/ accidents (not already listed):

Type	Date	Treatment Received	Outcome

Client Assessment Questionnaire

MEDICATIONS

List all the drugs (prescription pharmaceuticals) including dosages.
1. _____
2._____
3._____
4._____
5._____
6._____

Are you sensitive/allergic to any drugs, foods, chemicals, animals, environmental substances?
Yes No

If yes, please list:

_____
What happens when you have an "allergy attack"?

_____

What prior types of allergy testing have you had?

_____

CURRENT SUPPLEMENTS

List all vitamins, minerals, herbs, homeopathics, with dosages:
1._____ 6._____
2._____7._____
3._____8._____
4._____ 9._____
5._____10._____

PERSONAL

How would you describe your general health? _____

Are you happy in your job or career? □ Yes □ No

What would you like to change most about your life? _____

_____

What behaviors, habits, or thoughts would you like to eliminate? _____

_____

Do you drink alcohol? □ Yes □ No How often? wine _____ beer _____ other: _____

Do you use tobacco or have you in the past? □ No □ Yes, How long? ____ How much daily?____

Client Assessment Questionnaire

Do you exercise? □ Yes □ No
If yes, Current Physical Activity Level (circle one): low moderate heavy

How often? _____
Describe typical activity during week:
_____

What are your interests or hobbies? _____

DIET

Do you follow a special dietary plan, such as low cholesterol, kosher, or vegetarian? yes no
If yes, please explain: _____
_____

What change(s) would you like to make?
□ Improve my eating habits □ Learn to manage my weight □ Improve my activity level
Other _____

What information would you like to gain from your one-on-one session?

□ Weight Management □ Improve Health □ Exercise □ Supermarket Shopping Tour
□ Sports Nutrition □ Meal Planning
□ Other specify _____

How many meals do you generally eat each day? □ One □ Two □ Three □ More than three __

Do you: □ Eat out often □ Diet frequently □ Skip meals frequently
Do you have any special diet or eating restrictions? □ Yes □ No if yes, please explain:
_____

List the primary foods that are in your diet: _____
_____

List the foods you exclude from your diet: _____
_____

Mark which of these you consume regularly. □ Coffee □ Caffeinated teas □ Artificial sweeteners
□ Processed foods □ Preservatives □ Refined foods □ Margarine □ Fast Food □ Sugar/sweets

List any foods you crave, regardless of their nutritional value (include sweets, chocolate, bread, salty, sour, rich, fatty foods, etc.) _____
_____

Are you thirsty often? □ Yes □ No, At night? □ Yes □ No
How much water do you drink daily? _____

Are you satisfied with your diet as it is now? □ Yes □ No If no, why not? _____
_____

SLEEP

Do you have trouble falling asleep? □ Yes □ No If yes, what keeps you up? _____
_____

Do you wake at night and can't fall back to sleep? □ Yes □ No
Do you wake feeling refreshed? □ Yes □ No