

Nutrition and Herbs.Com

Client Questionnaire FORM (A)

All information gathered from this questionnaire for the express purpose of determining the best health consultation advice for the client. This information is held in the strictest confidence.

Client Details

Name: _____

Postal Address: _____

City/Town: _____

State: _____ Post Code: _____

Date of Birth: ___ / ___ / _____

Gender: [M] / [F]

Height: _____

Weight: _____ [kg] / [lbs]

Occupation: _____

Hobbies: _____

Marital Status: _____

Questions about client's health

- What is your blood pressure?
- Do you have a high cholesterol level?
- Do you have diabetes?
- Do you have heart problems?
- Do you have allergies?
- Do you suffer from indigestion?
- Is your hair falling out?
- Do you have joint pains?
- Do you suffer from headaches?
- Do you have liver problems?
- Do you suffer from constipation?
- Do you have kidney problems?
- Do you have menstrual problems?
- Do you have muscle cramps?
- Do your nails split?
- Do you smoke?
- Do you drink too much alcohol?
- Are you a vegetarian or a vegan?
- Do you regularly eat meat?
- Do you regularly drink cows' milk?
- Do you drink Coca Cola /other soft-drinks?
- Do you often eat sugary foods?
- Do you have ulcers?
- Do you wake up feeling tired?
- Do you have sleeping problems?
- Do you have prostate problems?
- Do you suffer from any sexual disjunctions?
- Do you have varicose veins?
- Are you easily irritated?
- Do you suffer from any kind of depression?
- Do you often feel exhausted?
- Does your back ache?
- Are you an active or sedentary person?
- How much water do you drink daily?

What does your daily diet consist of?
.....
.....
.....
.....
.....
.....

Client's Medical History

What are your present health complaints?

.....
.....
.....
.....
.....

How long since you had your latest medical check-up?

.....

Are you on medications?

Have you been on medications in the past two years?

If yes, which medications, and for what?

.....
.....
.....
.....
.....

Which major diseases, if any, did you suffer from in the past 5 years?

.....
.....
.....
.....

Did you have any major surgical operation?

.....

Have you lately been diagnosed with any degenerative illness

.....

If yes, which illness or illnesses?

.....
.....
.....
.....