WILD CHIROPRACTIC OFFICE

INITIAL NUTRITIONAL INTERVIEW: CONFIDENTIAL CLIENT HEALTH QUESTIONNAIRE

All of your personal information will remain strictly confidential

Name: _____ Email: _____

Address: _____City, State: _____

Phone (primary):_____ (secondary):_____ (ext.):_____

Date of birth:_____ Age:_____ Gender:_____ Height:_____

Weight:_____ Would you like your weight to be different? _____ If so, what? _____

Occupation: _____ How many hours per week do you work? _____

Relationship Status: Single Married Divorced/Separated Children? _____ How old? _____

Blood Type (If known):_____ How did you hear about us? _____ Referred By: _____

What are your health concerns? (Reason(s) you are here: _____

_____

_____

_____

Previous treatments for this/these health concern(s)? _____

What would you like to accomplish/gain from visits are our office? _____

_____

Do you sleep well? _____ Do you wake up during the night? _____ If so, what time(s)?_____

What time do you go to bed? _____ What time do you generally wake up?_____

How do you feel when you wake up? _____

Do you smoke, drink coffee, caffeinated drinks or alcohol? (If yes, indicate how much, how often)

Cigarettes: _____ Alcohol: _____ Coffee/Caffeine:_____

Exposure to secondhand smoke for prolonged periods of time (now or in the past)? _____ If so, how long_____

What role does exercise play in your life? Activity? How often?_____

_____

Have you been exposed to toxic substances at work or at home? _____

How much water do you drink per day? _____ Allergies? If seasonal, when? For how long? _____

_____

Do you have any known allergies to medications or herbs? _____Please list: _____

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies/prescription or non-prescription medications, aspirin, NSAIDs, laxatives, diet pills, or any other supplements? ***Please list below (brands and amounts)***

_____

_____

_____

Are you currently under the care of a physician or other health care professional? _____

If so, what treatment(s) are you undergoing? _____

_____

Please list any surgeries, accidents, injuries, childhood diseases you have had along with type and date:

_____

_____

_____

Have you had any dental procedures done? i.e. fillings, root canals, pulled teeth, crowns, etc? _____

_____

What were your eating habits like as a child? (List types of food): _____

_____

_____

What percentage of your food is home cooked? _____ How often do you go out to eat?_____

Do you crave sugar? _____ Do you crave salt? _____ Other cravings: _____

Do you ever feel tired/bloated/gassy after meals? _____ If so, how soon after a meal? _____

Do you notice this with certain foods? Please list: _____

Any other known food intolerances? _____

Do you experience constipation, diarrhea or both? _____When/How often? _____

Do you ever feel excessively hungry? _____ Do you have a poor appetite? _____

Any family history of serious illnesses (circle those which apply/list which biological relative)

Diabetes _____ Kidney Disease _____ Asthma _____ Heart Disease _____

Arthritis _____ Gallbladder Disease_____ Cancer _____High Blood Pressure _____

Stomach/Intestinal Disorder_____ Other: _____

Any household pets or other animals you or family members are in close contact with often? _____

WOMEN ONLY

Age of your first period? _____ Are you periods regular? _____ How Frequent? _____

How many days is your flow? _____ Do you experience PMS? _____ Is it mild or severe? _____

Are you peri-menopausal? _____ When did this first occur? _____ Are you menopausal? _____ Last period?_____

List your symptoms of peri/menopause: _____

_____

How many pregnancies have you had? _____When? _____

How many children have you delivered and how were they born? (vaginally or by cesarean? _____

_____

Were there any complications associated with these births? Please explain _____

_____

_____

Did you receive antibiotics during labor? _____ Have you had a miscarriage or abortion? _____How many_____

MEN ONLY

Approximate age of onset of puberty? _____ # Of Children _____

Do you feel your libido is adequate? Yes No Comments: _____

Do you wake up at night to urinate? _____ How many times per night? _____

Do you have difficulty and/or pain with urination? Yes No Diminished volume or flow? Yes No

Do you enjoy daily activities? Yes No Do you feel apathetic or complacent about previously enjoyed sports,

hobbies, clubs, games, etc? Yes No If yes, explain_____

Do you notice feeling more agitated/irritable than previously? _____

Do you feel less assertive in daily life than previously? _____

Would you like to discuss men's health issues specifically? _____
