Client Health and Lifestyle Questionnaire

Name: _____Date of Birth: _____ Age: _____
Address: _____
_____

Contact (Please tick preferred method)
☐ Home: _____ ☐ Mobile: _____
☐ Work: _____ ☐ Email: _____

Health Fund: _____
Occupation: _____

Allergies and Intolerances

Foods, medication, environmental, plants, animals etc.
Please list: _____

Family Medical History
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:
Cancer (specify type): _____ High Blood Pressure: _____
Heart Disease: _____ Stroke: _____
Bleeding or Clotting: _____ Asthma/ COPD: _____
Diabetes: _____ Other: _____

Personal Medical History

Please list all prescription and non-prescription medicines, vitamins, birth control pills, herbs etc.

Medication	Dose	Reason	Times per day

Personal Medical History

Please indicate whether you have had any of the following:

Surgery	☐ Yes	☐ No	Area/ Date: _____
Hospitalisation	☐ Yes	☐ No	Reason/ Date: _____
Pregnancies	☐ Yes	☐ No	Birth Dates: _____
Miscarriages	☐ Yes	☐ No	Dates: _____
Mammograms	☐ Yes	☐ No	Date of Last: _____
Vaccinations	☐ Yes	☐ No	Reason/ Date of Last: _____
Mental/ Emotional Traumas	☐ Yes	☐ No	Reason/ Date: _____

Accidents/ Traumas

Motor Vehicle	☐ Yes	☐ No	Injury/ Date: _____
Falls	☐ Yes	☐ No	Injury/ Date: _____
Sporting	☐ Yes	☐ No	Injury/ Date: _____
Other	☐ Yes	☐ No	Injury/ Date: _____

Lifestyle

Do you exercise regularly? ☐ Yes ☐ No How often per week: _____

Type of Exercise: _____

Height: _____ Current Weight: _____

Are you a smoker? ☐ Yes Packs per day: _____ No. of years: _____

☐ No ☐ Ex-Smoker Quit Date: _____

Are you interested in quitting?	☐ Yes	☐ No
Do you take other drugs?	☐ Yes	☐ No
Do you have a regular sleep pattern?	☐Yes	☐ No
Do you have difficulty getting off to sleep?	☐ Yes	☐ No
Do you wake tired?	☐ Yes	☐ No
Do you wake continuously?	☐ Yes	☐ No

What time do you usually: Go to bed: _____ Wake up: _____

System Review

Please indicate whether you have experienced or are currently experiencing any of the following:

Cardiovascular	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol
	☐ Diabetes	☐ Circulation Difficulties	☐ Clotting (Thrombosis)
	☐ Stroke/ TIA	☐ Other: _____	
Respiratory	☐ Asthma	☐ Apnoea	☐ Snoring
	☐ COPD	☐ Sinus/ Hayfever	
	☐ Other: _____		
Gastrointestinal	☐ Heartburn	☐ Irritable Bowel	☐ Changed Bowel Habits
	☐ Ulcers	☐ Other: _____	
Urinary Tract	☐ Kidney Disease	☐ Incontinence	☐ Difficulty/ Pain Urinating
	☐ Urinary Tract Infection		
Neurological	☐ Dizziness/ Vertigo	☐ Fainting	☐ Numbness/ Nerve Damage
	☐ Altered Sensation	☐ Other: _____	
Cancer	☐ Yes	☐ No	
	Area/Date: _____		
Endocrine	☐ Thyroid Problems	☐ Period Pain	☐ Menopause Problems
	☐ Polycystic Ovaries	☐ Endometriosis	
	☐ Other: _____		
Musculo-skeletal	☐ Fracture	☐ Osteoporosis	☐ Disc injury
	☐ Dislocation	☐ Sprain/Strains	
	☐ Other	☐ Specify Area/ Date: _____	
Immune	☐ Allergy	☐ Auto Immune Condition	☐ Reoccurring Colds and Flu
Skin	☐ Eczema	☐ Psoriasis	☐ Dermatitis

Health and Lifestyle Goals

What are your health and lifestyle goals? _____
_____

How do you rate your current level of: (1-10, 10 being excellent/ high)
Health: _____Vitality: _____Lifestyle: _____Stress: _____

Over what period of time do you think it will take for you to achieve your health and lifestyle goals?

☐ 3 months ☐ 6 months ☐ 12 months ☐ 2 years ☐ Longer

Are your signs and symptoms a result of: ☐ Short-term factors ☐ Long-term factors

What current behavioural or lifestyle habits do you believe need to change to benefit your health?

☐ Diet ☐ Exercise ☐ Rest ☐ Relaxation
☐ Occupation ☐ Addictive behaviours ☐ Emotional responses

Which of these areas of your life would you like to improve on first? _____
_____

What is your current level of commitment in addressing your health issues and their underlying causes?
(Please circle – 1-10, 10 being high)

1 2 3 4 5 6 7 8 9 10

Are you willing to change your diet? ☐ Yes ☐ No ☐ Maybe
Explain: _____

Have you previously taken or are you willing to take herbal medicines, nutritional supplements or homeopathic medicines to improve your health?

☐ Yes ☐ No ☐ Maybe
Explain: _____

Are you willing to increase your fitness and strength with an exercise program?

☐ Yes ☐ No ☐ Maybe
Explain: _____

What do you think could prevent you from achieving your health potential?

☐ Time Constraints ☐ Commitments ☐ Financial Resources ☐ Effectiveness
☐ Lack of Interest ☐ Emotional Support ☐ Other: _____

In order to achieve your health potential, what type of education, training or motivation would benefit you?

☐ Facebook ☐ Emails ☐ Phone support ☐ Books/ Magazines
☐ Newsletters ☐ DVD's ☐ Seminars ☐ Other: _____

I declare this information to be true and correct to the best of my knowledge.

Signature: _____ Date: _____