

## Raw Food Initial Session Form

### Bradley Wellness, LLC

#### client information

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Ph# \_\_\_\_\_

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#### Lifestyle / wellness / nutrition information

Current weight \_\_\_\_\_ ideal weight \_\_\_\_\_ weight one month ago \_\_\_\_\_ one year ago \_\_\_\_\_

Height \_\_\_\_\_

Relationship status \_\_\_\_\_ Children \_\_\_\_\_

Occupation: \_\_\_\_\_ Currently working: Y / N

What physical demands does your job require? \_\_\_\_\_

How many hours per week do you work? \_\_\_\_\_

How many hours per day do you sit in front of the computer? \_\_\_\_\_

Is your work space set up ergonomically correct? \_\_\_\_\_ please explain \_\_\_\_\_

What time do you go to sleep? \_\_\_\_\_ what time do you wake up? \_\_\_\_\_

Do you sleep well? \_\_\_\_\_

How many hours per night? \_\_\_\_\_ Do you wake up at night? \_\_\_\_\_ to urinate? \_\_\_\_\_

Do you feel rested when you wake up in the morning? \_\_\_\_\_

How many bowel movements do you have each day? \_\_\_\_\_

Constipation / Diarrhea? Explain \_\_\_\_\_

Gas / bloating / stomach issues etc? \_\_\_\_\_

Women:

Are your periods regular?

How many days of flow?

How frequent?

Painful or symptomatic?

Are you pregnant (or possibly?) What kind of birth control do you use or did you use?

Hobbies: \_\_\_\_\_

What was your health like at age 20?

How is your energy level?

What role does exercise and activity play in your life? \_\_\_\_\_

What type of exercise do you engage in? \_\_\_\_\_

How often? \_\_\_\_\_

Duration and Intensity per session? \_\_\_\_\_

If you could do any type of exercise, what would you do? \_\_\_\_\_

Do you feel pain in your chest when doing physical activity? In the past month, have you experienced pain in your chest when you are not doing physical activity?

Do you have a hearing/vision or other physical challenge that limits your activity in any way?

Do you smoke? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you use caffeine? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you use any other mind-altering substances? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Have you had a history of drug or alcohol abuse? If so, when and what treatment have you undergone, if any? Are you under current treatment?

Do you have panic attacks or frequent bouts with anxiety? Do you have a history of panic attacks?

Have you been in psychotherapy for an issue? Was there a diagnosis?

Have you ever been hospitalized for psychiatric or addiction reasons? If so, when, and for what issues?

Current treatment, if any:

Current physical/mental health challenges: for each condition that applies, please give the approximate date it developed, was diagnosed, and current status.

Arthritis

Asthma

Bone or joint problems

Bowel disorder (chron's, colitis, IBS, etc)

Cancer

Candida Albicans (yeast infection)

Cardiovascular disease, heart attack, other heart condition or surgery

Diabetes

Dizziness or loss of balance or consciousness

Epilepsy or seizure disorder

Hypertension/high blood pressure

Hypoglycemia (low blood sugar)

Immune system imbalance (lupus, Epstein-barr, HIV)

Liver Disease (Hepatitis, Hepatitis C)

Nervous System Disease (MS, Parkinson's)

Ulcers

Urinary tract disorders (kidney, bladder)

Weight loss or gain

List any other health challenges:

How is your oral / dental health? do you have root canals?

Past prescribed medications \_\_\_\_\_

Current prescribed medications you are taking: \_\_\_\_\_

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Past ailments / serious injuries / hospitalizations / illnesses?

How is the health of your mother and father / family health history?

What is your chief concern?

What are other concerns / future physical or mental health concerns?

Other healthcare professionals you have visited?

Healthcare professionals you are currently visiting?

What percentage of your food is prepared at home?

Where do you get your other food?

Do you have any food allergies or food sensitivities? What foods?

What supplements do you take?

Supplements you have taken in the past?

What are your foods of choice? What do you crave?

What kind of diet have you eaten in the last 6 months?

Do you currently experience food binges? If so, what are your trigger foods? Do you have a history of an eating disorder (anorexia, bulimia, or compulsive over-eating)?

Do you have a current eating disorder?

Have you tried "dieting"? if so, what have you tried?

What else would you like to share?

What foods did you eat often as a child?

Breakfast

Lunch

Dinner

Snacks

Liquids

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What about one year ago?

Breakfast

Lunch

Dinner

Snacks

Liquids

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What's your food like these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

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How did you first learn about raw foods?

What is your history with raw living foods?

Why are you interested in raw living foods?

What are your goals with raw living foods?

Approximately what percentage raw do you do now?

What would you like to do?

If you currently enjoy raw living foods- what foods?

Do you have raw food preparation equipment (ie. High powered blender, juicer, dehydrator etc)?

Please share any additional information in regards to raw foods: