

Holistic Nutrition / Health 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# _____

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: _____

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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