



Holistic Nutrition for the Whole You

403 NE Casper St. – Roseburg, OR 97470

(541) 430-1078 Or (541) 498-2235

www.yourwholenutrition.com

Confidential Consultation Questionnaire

Date: _____ Phone Consultation: _____ Follow-up Date: _____ Fee: _____

Have you been referred to us? Please give us their name so we can thank them. _____

Name: Mr. _Mrs. _Ms. _Miss. _____

Married?

Divorced?

Single

Mailing Address: _____

Shipping Address: _____

City: _____ State / Province: _____ Zip/ Postal Code: _____

Day time Phone # (_____) _____ Evening Phone #:(_____) _____ Email: _____ @ _____

Primary Health Care Provider: _____ Are you a Veteran or in the Military? Y N

Sex: M F DOB: _____ Age: _____ Weight: _____ Height: _____ Blood Type: _____

Blood Pressure: _____/_____ Pulse: _____ Average Blood Sugar: _____ Hours of Sleep Nightly _____

Your Cholesterol #'s HDL: _____ LDL: _____ VLDL: _____ Triglycerides: _____

Cultural Heritage: (e.g. English, French, Scandinavian, Italian, Irish, German, Native American, African America) _____

(For Women) Are you pregnant? Y N Are you still menstruating? Y N When was your last period? _____

Are your periods: Heavy Regular Light Spotty Painful Irregular Do you have vaginal dryness? Y N

Are you on Birth Control? Pill Shot Implant Patch Other: _____ Have you had any miscarriages? Y N

Hysterectomy? Y N HRT Therapies Y N

(For Men) Your last prostate exam? _____ Have you had prostate surgery? Y N

(Men & Women) Describe your interest in sex. good fair poor excellent Are you sexually active? Y N

Do you have living children? Y N Salivary Hormone test Y N Thyroid test Y N

Hair Analyses Y N

Have you had any surgery? Y N If yes, please tell us what for:



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Are you currently under a physician's care? Y N What for?

Are you currently on any medications prescribed by a health care provider? Y N Please list them below

Are you currently taking any nutritional supplements? Y N If yes, please list the name brands, product and dosage.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you a vegetarian? Y N

Do you have religious dietary needs? Y N

How many times in the last two years have you been on antibiotics? _____ When? _____

How frequent are your bowel movements? One a day Twice Daily More? _____ Once a week

Describe your stool consistency?	Hard and sinks	Light in color
Soft and easy	Loose sometimes watery	Diarrhea
Easy floater	Dark in Color	Chronic Constipation

How frequently do you urinate? _____ **Color of Urine:** Dark Yellow Brown Orange Yellow Light Yellow Clear

Does your urine have a strong odor? Y N

Please list the foods you eat the most frequently.

Are there any foods you crave? _____ Foods you can not eat for any reason? _____

Describe a typical breakfast, lunch and dinner:

Breakfast: _____	Lunch: _____	Dinner _____
_____	_____	_____
_____	_____	_____

Do you ever skip meals? Y N

Do you eat between meal snacks? Y N

List Snacks _____



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Do you use: Margarine Butter Olive Oil Corn Oil Coconut Oil Other: _____

Do you like spicy foods or condiments? Y N Do you use real mayonnaise? Y N

Do you use salad dressing from the refrigerator section at the market or off the shelf: Shelf Refrigerated

Do you eat nuts? Y N Raw Roasted What is your favorite nut? _____

Do you eat? White bread Whole Grain Bread Sprouted Grain Bread Whole Wheat Bread

Pasta White Rice Brown Rice Russet Potatoes Red Potatoes

How many times a week do you eat out or eat prepared packaged or canned food? _____

Do you eat fish? Y N What types: _____

What is your primary meat or vegetable protein source? _____

Do you eat vegetables: fresh frozen canned How many times a week ? _____

Do you eat fruit fresh canned dried frozen How many times a week? _____

Do you drink. Black Tea Decaf Soda Pop Diet

Alcohol Green Tea How many pops a day? _____

Coffee Decaf Red Tea Energy Drink

How many cups of coffee a day? _____ Herbal Tea Water in ounces Daily _____

Filtered Water Y N

Do you prefer food over supplements? Y N Do you have a hard time remembering to take supplements? Y N

Do you have family and or friends to help motivate you with your health choices. Y N

Do you get regular exercise? 1-7 days a week: _____ How many hours or minutes do you generally exercise at a time? _____

Do you spend time out in the sun? Y N Do you use Sunscreen? Y N SPF? _____ Do you use full spectrum lighting? Y

Do you attend a Church, Synagogue, Mosque, Temple, Drumming, or Centering Group on a regular basis? Y N

How often do you listen to music? _____ What is your favorite color? _____

What do you do to pamper or treat yourself? (eg. hunting, camping, fishing, skiing, spa, massage, new cloths, shopping, reading, manicure, sunbathing)

Please tell us what your goal is by requesting a consultation.



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PLEASE CHECK OR CIRCLE ALL BOXES AND OR ANSWERS THAT APPLY TO YOU AND ARE DIAGNOSED :

- | | | |
|--|---|--|
| <input type="checkbox"/> Flatulence / GAS | <input type="checkbox"/> Skin Problems / Eczema, Rosacea, Acne, Liver spots / Dry or Oily | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Rheumatoid / Osteoarthritis | <input type="checkbox"/> Cataracts / Floaters / Macular Degeneration | <input type="checkbox"/> Food Allergies / Food Sensitivity |
| <input type="checkbox"/> Sports injuries | <input type="checkbox"/> Kidney Health | <input type="checkbox"/> Polycystic Ovarian Disorder (POD) |
| <input type="checkbox"/> Allergies / Seasonal, Food, Environment | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Digestive Problems / IBS / Crohn's / Gastric Bypass / Celiac disease / Colitis / Ulcers |
| <input type="checkbox"/> Hair – Dry / Brittle / Losing / Dandruff / "Strawlike" or Unmanageable hair | <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Help Losing Weight / or Gaining |
| <input type="checkbox"/> Alzheimer's / Parkinson's Disease | <input type="checkbox"/> Low Libido | <input type="checkbox"/> Gall bladder Removal |
| <input type="checkbox"/> Headaches / Cluster, Migraine, Sinus | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tonsillectomy / Adenoids |
| <input type="checkbox"/> Stress / Anxiety / PTSD | <input type="checkbox"/> Shingles | <input type="checkbox"/> Appendix Removed |
| <input type="checkbox"/> Hearing Loss / Ringing / Infections / Wax | <input type="checkbox"/> Prostate Problems / PID | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Heartburn / Acid reflux | <input type="checkbox"/> Constipation | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Thyroid Problems / Hypo / Hyper | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hashimoto's | <input type="checkbox"/> Bitten by a Tick | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tattoos |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Herpes 1 -2 | <input type="checkbox"/> Cravings | <input type="checkbox"/> Use Recreational Drugs / Medical Marijuana |
| <input type="checkbox"/> Urinary Tract Problems / Cystitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> IV Drug use |
| <input type="checkbox"/> Varicose Veins / Spider Veins | <input type="checkbox"/> Adrenal Fatigue / Addison's Disease | <input type="checkbox"/> Irregular Heart Rhythm |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Menopause /Hot Flashes | <input type="checkbox"/> ADD / ADHD / Autism |
| <input type="checkbox"/> Back / Neck Pain / Sciatica / Herniated / Bulged / Slipped / Degeneration / Ruptured disk | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Finger nails: Chip easily, dry, brittle, peel, weak, slow growing. |
| <input type="checkbox"/> Blood Clots /Stroke / Hypertension | <input type="checkbox"/> Menstrual Cramps / PMS | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Bone Spurs | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Fibrocystic Breasts |
| <input type="checkbox"/> Fluid Retention | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> High Risk Sexual Activity |
| <input type="checkbox"/> Cancer / Cancer Treatments | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Candida | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Syndrome X or Metabolic Syndrome |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Periodontal Disease | <input type="checkbox"/> Hard Bumps on Arms, Thighs or Elbows |
| <input type="checkbox"/> Snoring /Sleep Apnea | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Wilson's Syndrome |
| <input type="checkbox"/> Weakened Immune System Frequent Colds or Flu | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Myocardiopathy |
| <input type="checkbox"/> OPD | <input type="checkbox"/> Diabetes 1 or 2 | <input type="checkbox"/> Abdominal Fat |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Cold Body Temp. |
| <input type="checkbox"/> Smoking Dependency | <input type="checkbox"/> Muscle Stiffness / Soreness | <input type="checkbox"/> Thinning Skin |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Decreased Muscle Mass |
| <input type="checkbox"/> Irritability / Depression / SAD | <input type="checkbox"/> Rare Blood Diseases | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Cholesterol (High) / High Triglycerides | <input type="checkbox"/> Environmental Poisoning | <input type="checkbox"/> Decreased Urine Flow |
| | <input type="checkbox"/> Leg twitches or Cramps | |



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DISCLAIMER

- This information is for nutritional evaluation based on family history or medically diagnosed health challenges; it is not to be construed or used as medical diagnosis. To the best of our knowledge, the following information has not been evaluated by the FDA. The information presented is intended for educational purposes only and is not intended to be a substitute for professional medical advice, diagnosis, or treatment.
- Any information or products you may choose to use requires your personal responsibility in accordance with the manufacturer's guidelines or those of your health care provider.
- All client information will be kept confidential. All client information will be released only to the client in person with photo ID. All client information will remain on file or in storage for a time frame designated by your nutritional consultant.
- Client health challenge information may be used as anonymous research information. At no time will personal names, addresses or potentially other sensitive information be used.
- At no time will this office or our affiliates retain, store or file credit card information. This information must be presented at the time of service with ID.
- We do not control the manufacture of dietary supplements, topical products, formulation, or quality of these products, nor do we control any statements written by third parties about the products or products listed.
- We are not liable for any personal injury or mental anguish including death, caused by the use of any information provided by third parties or products you purchase. The information provided is intended as educational and we do not have any control over how you may choose to use said information, therefore we cannot be held responsible for your actions.

I understand that I will be billed \$60.00 if I miss two consecutive appointments without 24 hours notice.

I understand and agree to the conditions of this nutritional consultation:

Date: _____