Health Questionnaire

Please note that all information provided is strictly confidential and will not be disclosed to anyone without your permission.

Patient Details

Name: .... Date of First Visit: ....

Address: ....

Phone No: .... Email: ....

Occupation: .... Date of Birth: ....

Height: .... Weight: ....

Main Reason For Visit: ....

....

Existing conditions: ....

....

What are your main health goals
(List in order of priority): ....

Please list all current medication
you are taking: ....

Please indicate in the box below any supplements you are currently taking:

If you are not currently taking any supplements just circle **N/A**

Brand	Name of Product	Dosage per Day

	Yes	No	If yes please specify
Have you had any medical exams/ tests/x-rays/radiation/chemotheraphy in the last 5 years?	☐	☐	
Have you ever had any surgical operations?	☐	☐	

Lifestyle Factors

Do you drink alcohol? Yes / No

Do you smoke? Yes / No

Roughly how many glasses of water do you drink each day? ....

Do you drink Coffee? Yes / No If so how many cups? ....

Do you drink Tea? Yes / No If so how many cups? ....

Do you drink Juice? Yes / No If so how many cups? ....

Do you drink Fizzy drinks? Yes / No If so how many cups? ....

Do you take part in any form or exercise during the week? If **yes** please state type of exercise and how long your sessions are? ....

Please list any foods you:

Have an intolerance to	Avoid	Crave

What would a typical day look like with regards to food eaten?

	Weekday	Weekend
Breakfast		
Lunch		
Dinner		
Snacks		

Thank you for providing me with this valuable information