Consultation Questionnaire

Name _____ Date_____
Full Address
_____
Phone (home) _____ Phone (work) _____ Email address_____
How did you hear about Total Wellness?
_____
AGE _____ HEIGHT _____ WEIGHT _____

Please answer the following questions frankly, to the best of your knowledge:
All information **is held in strict confidence.**

Weight Loss Clients:

DESIRED WEIGHT _____
Write briefly about any weight fluctuations you have had in the past few years.
_____
_____
What do you feel triggered your initial weight gain? (circle) HEREDITY EATING HABITS STRESS HORMONAL BOREDOM SMOKING CESSATION OTHER _____
Was your weight gain (circle): SUDDEN GRADUAL PROBLEM SINCE CHILDHOOD
How long have you been overweight?_____
What other family members are overweight?
_____
What other methods have you used to lose weight?
_____
How many meals do you eat per day? _____Which ones?
_____
What foods do you overeat that you feel contribute to your weight gain?_____
Is there a specific time you feel overeating is a problem?
_____

All Clients:

Please describe a typical day's meals:

_____
Breakfast
_____
Lunch
_____

Dinner
_____

_____
Snacks

Describe your appetite for morning, afternoon, and night
_____

Do you have any food allergies or restrictions?
_____

Do you crave any of the following foods? (Please Circle) Sweets Breads Fatty Foods Meats Fish Milk Others _____

How is your skin? (Circle) Dry Very Dry Oily Combination Smooth Other _____

How is your energy level?_____

Which fats do you use? (Circle) Margarine Butter Olive Oil Safflower Sunflower Corn Crisco Canola Peanut Soybean Mayonnaise Flax

Number your favorite flavors in order of preference. Sweet ___ Sour ___ Salty ___ Spicy ___ Bitter__

Do you take any nutritional supplements? Which ones?
_____

Medical Information:

Who is your primary care physician? Name
_____
Address _____ Phone
_____
When was the last time you had a complete physical?
_____

Do you or have you had any of these conditions? (circle) HIGH BLOOD PRESSURE HYPOGLYCEMIA HEART PROBLEMS HIGH CHOLESTEROL CANCER KIDNEY PROBLEMS PREGNANT DIABETES (INSULIN) DIABETES (DIET) LIVER PROBLEMS GOUT SKIN CONDITIONS INTESTINAL PROBLEMS LUNG DISEASES THYROID COND. ANEMIA CHRONIC FATIGUE YEAST INFECTIONS BLADDER / UT INFECTIONS STROKE LIVER DISEASE ARTHRITIS GALL BLADDER DISEASE PARASITES SKIN CONDITIONS VIRAL/BACTERIAL DISEASE SEIZURES DEPRESSION FAINTING SEVERE MOOD SWINGS HEARTBURN HEMORRHOIDS CHRONIC COLD/FLU SYMPTOMS
Other
_____
_____

Are there any medications you take on a regular basis? _____ If yes, which ones?_____
_____
_____
Have you had any traumatic accidents, surgeries or operations? (describe)_____
_____

_____
What forms of exercise do you get, how often?
_____
How much sleep do you get on average each night? _____ How do you sleep?
_____
Do you smoke, drink alcohol, or use recreational drugs? How much?
_____
Do you drink coffee? Tea? Soda? _____ How much and when?
_____
Are there any times of the day when you feel best? _____ Worst?
_____
How often do you move your bowels? _____ Urinate?
_____
Do you like your current career?_____ Is there much stress in your life?
_____
Are you happy with your life right now?
_____

Is there anything else you would like us to know about you? :

Women Only:
Who is your gynecologist? Name
_____
Address _____ Phone
_____
Are you currently pregnant or are you a nursing mother?
_____
Have you had any of the following? (Circle) Children # _____ Hysterectomy Menopause
Do you have severe PMS?_____ How is your period?
_____

Thank You!