Better Health Clinic

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Biography and Biology Client Assessment Form

This assessment was designed to help discover issues that could be related to a nutritional imbalance in the body. This form was not designed to diagnose diseases.

General Information:

Name:_____Date:_____

Address:_____City:_____

Phone: ( )_____Email:_____ Gender: M / F

Date of Birth:_____ Age:_____ Married/ Divorced/ Single

Number of Children:_____ Occupation:_____

Health Concerns:

What are your 3 most important health concerns?

1. _____
2. _____
3. _____

What is the main reason for making this appointment today?

_____

How have you dealt with any of the above concerns in the past?

- Doctor
- Self-care
- Other: _____
- Have not dealt with them at all

Have you experienced any success with any of these approaches? Please explain, _____

_____

Are you currently seeing any other health practitioners?

_____

Your height: _____ Your weight: _____

What is your stress level at this point in your life? (Circle one)

Not manageable (very high) ~ Sometimes Manageable (high) ~ Manageable (moderate) ~ Very Manageable (low) Anything to Add: _____

Do you sleep through the night? YES / NO / SOMETIMES

How many hours, on average do you sleep at night? _____

Do you wake feeling rested? YES / NO / SOMETIMES

Do you fall asleep easily? YES / NO / SOMETIMES

What time do you normally go to bed? _____ What time do you awaken? _____

How many hours a day do you work? _____ How many hours a week do you work? _____

Do you enjoy your work? YES / NO / SOMETIMES

Were you bottle-fed or breast-fed as a baby? BOTTLE / BREAST / NOT SURE

Were you a vaginal birth or a c-section birth? VAGINAL / C-SECTION

Medical History:

Have you had any surgical procedures? Please list,

_____

How often did you take antibiotics as a child? *Never ~ 1-2 times ~ 2-5 times ~ lots*

Have you taken antibiotics in the past 2 year? YES / NO / NOT SURE

Briefly explain your medical history:

_____

_____

Are you currently on any medications: YES / NO ~ please list them/ reasons?

_____

_____

Please list any past medications that you have not listed above:

_____

Has there been any significant head trauma in your past? YES / NO ~ Please explain:

_____

Have you ever been diagnosed with any diseases/ illnesses? (Include past and present)

_____

Have you ever been hospitalized? YES / NO ~ For what reason?

_____

Do you experience any of the following: (Circle all that apply)

Headaches ~ Migraines ~ Acne ~ Psoriasis ~ Eczema ~ Dry Skin ~ Brittle Nails ~ Brittle Hair ~ Stretch Marks ~ Dizzy When Standing ~ Bruise Easily ~ White Spots on Nails ~ Cold Sores ~ Sore Joins ~ Sore Bones ~ Lower Back Pain ~ Mood Swings

Do you suffer from allergies? YES / NO ~ Explain:

_____

Nutritional Status:

Have you ever seen a Nutritionist before? YES / NO

Are you currently taking any supplements: YES / NO ~ Please list:

_____

Please list any other minerals, herbals, homeopathic remedies you are currently taking:

_____

Where do you normally purchase your supplements and other holistic items? _____

Do you grocery shop? _____ Where do you normally grocery shop? _____

How often do you have a bowel movement? _____

When you have, a bowel movement is it easy or do you strain? (Circle one)

Very easy (30 sec or less) ~ Pretty easy (1-5min) ~ A little hard (5-10min) ~ Very hard (15min +)

Are there any foods you avoid because of the way they make you feel after eating them? If yes, please name the food and the symptoms experienced:

_____

Do you experience any of the following symptoms after eating? (Circle all that apply)

Heart burn ~ Acid Reflux ~ Burping ~ Bloating ~ Nauseous ~ Gas ~ Cramping

Lifestyle:

Are you often sick/ ill and miss work/ school? Explain:

_____

Are you often sad/ depressed and miss work/ school? Explain:

_____

How many times do you drink alcohol a week? (Circle one)

Never ~ Rarely ever ~ 1-2 times a week ~ 3-5 times a week ~ Every night

Do you smoke? _____ How much do you smoke? _____ How long have you smoked? _____ Have you quit before? _____

How often do you exercise? (Circle one)

Rarely ~ 1-2 times a week ~ 3-5 times a week ~ 7 days a week

What form of exercise do you do?

_____

What are your hobbies/ interests?

_____

Do you regularly use air fresheners in your home/ car/ workplace? _____

Do odors affect you? YES / NO / SOMETIMES

Dietary Status:

How many meals do you usually eat a day? _____

What time of day would you normally eat Breakfast:_____ Lunch:_____Dinner:_____

On a typical day what would you eat for:

Breakfast:_____

Lunch:_____

Dinner:_____

Snack:_____

Do you regularly use a microwave? YES / NO / SOMETIMES

On a scale of 1-10 how healthy, would you say your diet is? (1 being not healthy and 10 being very healthy) *1 ~ 2 ~ 3 ~ 4 ~ 5 ~ 6 ~ 7 ~ 8 ~ 9 ~ 10*

Which of the following foods do you consume regularly? (Circle all that apply)

Soda ~ Diet Soda ~ Refined Sugar ~ Fast Food ~ Gluten(wheat,barley,rye) ~ Dairy (milk,yogurt,cheese) ~ Coffee ~ Processed Foods ~ Margarine ~ Fried Foods ~ Candy

Please list all liquids you consume in an average week? (i.e -milk, fruit juice, Gatorade, water...)

_____

List any known diets you have been on: (i.e, weight watchers, isagenix, juice fast, vegetarian, ect.) _____

What % of your meals do you cook at home? (Circle one)

10-20% ~ 30-40% ~ 50-60% ~ 70-80% ~ 100%

How many times a week do you dine out or get take out? _____

What are your favour places to go out for a meal? _____

Do you have food cravings? If so, what do you crave? _____

Describe your diet, ex- meat eater, vegetarian, vegan, I only eat eggs, I don't eat fish…..etc.…

_____

How often do you eat gluten products that you are aware of? (Circle one)

Once a week or none ~ 3-5 times a WEEK ~ Every day ~ 2-4 times a DAY

Mental Health Status:

How is your mood on a day-to-day basis? (Circle all that apply)

Angry ~ Sad ~ Depressed ~ Anxious ~ Happy ~ Frustrated ~ Paranoid ~ Lost

Please Explain Further: _____

_____

When did you start feeling that way you feel now? _____

From 1-10 how would you rate your energy level? *Low1 ~ 2 ~ 3 ~ 4 ~ 5 ~ 6 ~ 7 ~ 8 ~ 9 ~ 10 High*

How does your brain function on a daily basis? (Circle all that apply)

Perfect ~ Alert ~ Fast ~ Slow ~ Foggy ~ Frustrated ~ Other: _____

Woman Only:

Are you currently trying to get pregnant?_____

Are you or could you be pregnant?_____ Are you currently breastfeeding? _____

Describe your periods: _____Mood Swings: _____

Do you or did you have PMS? _____

Are you pre-menopausal? YES / NO / MAYBE Post-menopausal? YES/ NO

Have you ever experiences any yeast infections? _____ If yes how many? _____

Have you ever had any urinary tract infections? _____ If yes how many? _____

Have you, or do you still take birth control pills? _____ Please list the length of time: _____

Have you ever had any difficulty with conception or pregnancy? _____ If yes, please explain: _____

Other Information:

Do you have a good support system at home? _____

Please describe any other information you think would be useful in helping to address your health concern(s): _____

_____

What are the main results you would like to achieve by seeing a nutritionist? _____

_____

CLIENT STATEMENT:

I understand and acknowledge that the services hereby provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnoses, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily. All information shared will be kept strictly confidential.

Today's date: _____

Signature: _____

Name (printed): _____

Address: _____ *City:* _____

*Provence:*_____ *Postal Code:* _____

Phone (Home): _____ *Phone (Cell):* _____

Email: _____

Privacy Policy:

I understand that a record will be kept of the nutritional services provided to me. This record will be kept confidential in accordance with the provincial laws and will not be released to others unless so directed by myself unless law requires it.

If required, I understand that Hannah Moore CNP may discuss my case with other healthcare providers.

I understand that Hannah Moore CNP and The Better Health Clinic will take all necessary steps to provide adequate privacy of my client file.

Client Consent:

I have read and understand the information above regarding the privacy policy of my _____*(print name) client file.*

Signature: _____ *Date:* _____