



Whole Nourishment

Health History

Today's Date:.....

Client name Age Date of Birth

Address:..... City: State: Zip:.....

Phone—home () other () email

How did you learn about Whole Nourishment?.....

Relationship status:..... Children? Occupation:..... How many hours a week do you work?

Do you sleep well? Do you wake up at nights? What time(s)?

What time do you generally get up in the morning?Do you feel refreshed?.....

How is your energy level?..... Any constipation/diarrhea?

Current weight Weight six months ago One year ago.....

Would you like your weight to be different? If so, what?

Women only: Are your periods regular? How many days is your flow? How frequent.....

Painful or symptomatic?Are you on any form of birth control?.....

Are there any doctors, healers, or therapies with which you are currently involved? For what?

Do you take any vitamins, herbs, or medications? If so, which? For what?.....

Any serious illness, hospitalizations, or injuries?

What role does exercise play in your life?

Do you drink coffee/soda, smoke, or have any addictions (sugar, chocolate, alcohol, etc.)?

What percentage of your food is freshly prepared?% What percentage of your food do you buy organic?%

How would you describe your overall health?.....

What is your primary health concern?

Other concerns?.....

What interests you most about seeing a Health and Nutrition Counselor?.....

(---OTHER SIDE PLEASE---

What foods did you eat often as a child ?

breakfast	lunch	dinner	snacks	liquids
.....
.....
.....
.....

What's your food like these days ?

Day 1

breakfast	lunch	dinner	snacks	liquids
.....
.....
.....

Day 2

breakfast	lunch	dinner	snacks	liquids
.....
.....
.....

Day 3

breakfast	lunch	dinner	snacks	liquids
.....
.....
.....

What was your food like a year ago (if different from above) ?

breakfast	lunch	dinner	snacks	liquids
.....
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.....
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