Treasure Coast Holistic Health Center

Inspired By Life…

In health, happiness, prosperity, & love

524 SE Dixie Hwy
Stuart, FL 34994

(772) 208-7688
TCHolisticHealthCenter@gmail.com

The purpose of this questionnaire is to gather information, and bring your attention to many details of your health. What you consume, how it moves through your body, how you process foods, the environment around you, exercise, and your sleep patterns are all vital to your health.

Name:_____ E-Mail:_____

Address:_____ Phone:_____

_____

_____

Date of Birth & Age:_____

Height:_____

Weight:_____

Health History:

1. What Medical concerns do you have, if any, at the present time? (circle & explain)

Pregnancy	Cancer Diabetes	Heart disease	High cholesterol	High blood pressure
Osteoporosis	Thyroid disorder	Bruising	Large Appetite	No Appetite
Constipation	Diarrhea	Indigestion	Menstrual difficulties	Seeing in dim light
Sudden Weight Change		Stress	Other	

_____

_____

_____

_____

_____

2. Does any of you family members or relatives suffer from any of the above? If yes please indicate your relation.

_____

___

3. Are you taking any medication? If yes please list what & how much.

_____
_____
_____

4. Are you allergic or intolerant to any foods or medicine?

_____
_____

5. Do you use tobacco or recently quit smoking?_____
6. Do you use drugs?_____
7. Do you drink alcholo?_____
8. Do you drink soda (either diet or regular)?_____
9. Do you use artificial sweetners?_____
10. Do you use margarine or oil spreads?_____

Work and Family History

11. Are you employed? If yes what do you do?

_____
_____

11a. What days/hours do you work?_____

11b. Do you enjoy what you do?_____

12. How many people in your household. What are their ages?

_____
_____

13. What is your marital status?_____

14. Do you have a support system of family and/or friends?_____

Diet History

15. Out of 35 meals per week how many of them do you eat out/not cook yourself?

(3 meals plus 2 snacks per day x 7 days a week=35 meals total)

_____

15a. Who is responsible for purchasing the food you eat?_____

15b. Who is responsible for preparing/cooking your meals?_____

16. Have you ever made food changes in your life that you felt good about?_____

17. Do you take any prescribed, over the counter, herbal, or vitamin/mineral supplements?_____

18. Do you follow a special dietary plan, such as low cholesterol, kosher, vegan, or vegetarian?_____

19. Have you ever followed a special diet? What did you find helped you? What did not work for you?

_____
_____
_____
_____
_____

20. Do you have any problems purchasing foods that you want to buy?_____

21. What change would you like to make?_____

Lose weight Lower cholesterol Manage diabetes Improve eating habits Family meal plan Personal meal

plan Learn to cook Learn to food shop on a budget

22. Any additional information you fell may be relevant to understanding your nutritional health.

_____
_____
_____
_____

Exercise history

23. How many times a week to you exercise?_____

24. Do you enjoy any type of exercise?_____

25. Does exercising bring you happiness? Please explain why or why not.

_____
_____
_____

26. Have you ever followed an exercise routine in the past? What did you like about it? What did you dislike about it?

_____
_____
_____
_____
_____

Elimination system:

27. Do you have a bowel movement daily?_____

28. Do you smell bad when you sweat?_____

29.. Do you use antiperspirant or deodorant? If yes, what brand_____

30. What type of soap/shampoo/conditioner do you use?_____

31. Are you exposed to cleaning chemicals, or any other chemicals?_____

Stress relief/activities/ and sleep history

32. How to you manage your stress?

Going to the gym Exercise Meditation Yoga Walking Cooking Dining out

Massage Facial Manicure/Pedicure Other Spa treatments Gathering with friends

_____
_____
_____
_____

34. What activities do you like? What clubs are you involved with?

_____
_____
_____

35. What time do you go to bed? What time do you wake up?_____

36. Overall how is your sleep? Do you sleep soundly, or do you wake up?_____

37. Do you have a support system? Who can encourage you to make positive changes in your life?

_____
_____
_____
_____

38. What are you looking to gain from our sessions?_____

_____
_____
_____

A week prior to our first meeting **please keep a log** of all foods and drinks you consume, times you eat, and the location you are while you are eating. Also please take note of your sleep times, and exercise routine. This will help tremendously in the evaluation process.

Thank you for your willingness to share this information, and take part in this journey that will improve your life. I am looking forward to working with you to make lifestyle changes to meet you specific needs.

I encourage you to visit your doctor for a physical prior to making the changes I am suggesting. Please feel free to share my suggestions with your physician, and get his/her opinion on them.

If there is any additional information you would like me to know, or your doctor has any specific recommendations please advise me of them.

Thank you again,

In Health and Peace,

Catherine.