Functional Wellness Minneapolis
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Helping People Get Out of Pain The Natural Way

PLEASE FILL OUT PROMPTLY ~ IT IS ESSENTIAL THAT I HAVE THE CORRECT EMAIL

Initial Interview: Confidential Client Health Questionnaire

**** All of your personal information will remain strictly confidential! ****

Name: _____

E-mail: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work/Cell:** _____

Date of Birth: _____ **Place of Birth:** _____

Age: _____ **Gender:** _____ **Height:** _____ **Weight:** _____

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

Occupation: _____ **How many hours do you work per week?** _____

Relationship Status: _____ **Children?** _____

Emergency Contact:

Name: _____ **Relationship:** _____

Phone: _____

Referred by/How did you come to hear about me? _____

Hobbies/Activities:

_____

What are your health concerns, please list at least Five: _____

_____

_____

_____

What would you like to accomplish/gain from this consultation? _____

_____

Do you sleep well? _____ **Do wake up during the night?** _____

If so, what time(s)?_____ **What time do you go to bed?** _____

What time do you generally wake-up? _____

How do you feel when you wake up? _____

_____

Do you drink caffeinated drinks? _____ **How much & how often?** _____

Do you smoke?_____ **How much & how often?** _____

If no, why, how and when did you quit smoking? _____

History Exposure/Secondhand Smoke? _____ **If so, how and how long?** _____

Do you drink alcohol? _____ **How much & how often?** _____

Do you drink soda (diet or regular)?_____ **How much & how often?** _____

What role does exercise play in your life? _____

Have you been exposed to toxic substances at work or home?

_____

How much water do you drink per day? _____

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/non- prescription medications, aspirin, laxatives, diet pills, or any other supplements? Please list all below including name brands and amounts (this is important,

YOU ARE WELCOME TO BRING THEM WITH YOU TO CHECK IF YOUR SYSTEM NEED THEM

(Additional Fee for testing)

Do you have any known allergies to medications or herbs? _____ **Please list all:** _____

Are you currently under a practitioner's care for a specific health issue? _____

If so, what treatments are you undergoing? _____

Please list any surgeries, accidents, injuries or childhood diseases you have had along with the type and date: _____

What were your eating habits like as a child? (List types of foods) _____

What percentage of your food is home cooked? _____

How often do you eat out? _____

What are the three worst foods you eat each week? _____

What are the three healthiest foods you eat each week? _____

Do you feel tired, bloated, and/or gassy after meals? _____

Do you experience constipation or diarrhea often? _____

When & how often? _____

Do you feel excessively hungry? _____ **Do you have a poor appetite?** _____

_____

Family Health History (Indicate Yes with a check mark)

Diabetes		**Kidney disease**		**Asthma**	
Heart Disease		**Arthritis**		**Gallbladder disease**	

Cancer		**Type of cancer**	
Stomach/Intestinal		**Other:**	

Mother: Age:		**Died from**	
Father: Age:		**Died from**	

Maternal Grandmother:		**Died from**	
Paternal Grandmother:		**Died from**	

Maternal Grandfather:		**Died from**	
Paternal Grandfather:		**Died from**	

WOMEN ONLY:

Age of your first period: _____ **Are your periods regular?** _____

How frequent? _____ **# Of pregnancies** _____

How many days is your flow? _____

Do you experience PMS? _____ **Is it mild or severe?** _____

Are you Peri-menopausal? _____ **When did this change first occur?** _____

Are you menopausal? _____ **When was your last period?** _____

List your symptoms of peri/menopause: _____

_____

_____

How many children have you delivered (vaginally or by cesarean)? _____

Were there complications associated with these births? _____

Please explain: _____

_____

Did you receive antibiotics during labor? _____

Have you ever had a miscarriage or an abortion? _____ **How many?** _____

_____

MALE ONLY:

Approximate age of onset of puberty: _____ **# of Children:** _____

Do you feel your libido is adequate? Y N Comments: _____

Do you wake at night to urinate? _____ **How many times per night?** _____

Do you have any difficulty and/or pain with urination? Y N Diminished volume or flow? Y N

Do you enjoy daily activities? Y N

Do you feel apathetic or complacent about previously enjoyed sports, hobbies, clubs, games, etc.? _____

Do you notices feeling more agitated/irritable than previously? _____

Do you feel less assertive in daily life than previously? _____

Would you like to discuss men's health issues specifically? _____

Life Style

List your favorite foods or cravings: _____

Estimated daily use of:

Coffee (Please note decaf or not?): _____

Tea (Please note caffeine or not?): _____

Soda (Please note caffeine or not? Diet of not?) _____

Beer		Wine		"Hard Liquor"	

I consider Myself:

Social Drinker		**In Recovery**	
Heavy Drinker		**Non-Drinker**	

Are you now, or have you ever been a smoker?_____How many years?

How much do you smoke (tobacco/pot)? _____

If you were a smoker and have quit, how many years have you quit? _____

When you were smoking how much did you smoke? _____

Estimated weekly exercise (please provide details): _____

I think this is enough exercise	**I would like to do more exercise**

I find my work:

Too demanding	**Boring**	**Satisfactory**	**Very Satisfying**

I sleep well Yes No

I worry about ~ mark all that apply

Money	**Job**	**Family Life**	**Relationships**	**Other _____**

I currently see a psychotherapist or other mental health professional Yes No

I have had Rolfing and/or Cranio-sacral Therapy Yes No

I currently see a massage therapist, Rolfer, chiropractor, osteopath or other physical therapy professional Yes No Please circle which provider(s) you use.

I have been in the military service Yes No

I have been a victim of abuse? Physical Sexual Emotional

In my life I am safe emotionally? Yes No Physically? Yes No

My spiritual life is satisfactory Yes No

I am currently involved in a spiritual program Yes No