NEW CLIENT EVALUATION

Today's Date: ________________ Referred by: ____

Name: ________________________________ M ☐ F ☐ Birth date _ _/_ _/_ _ Age ____ Height _____

Mailing Address: ____

City: ___________________ State: _____ Zip: ___________ Occupation: __________________________

E-mail Address: ____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Number of children: ______________

Phone Number: Day (_____) __ __ __ - __ __ __ __ Evening (_____) __ __ __ - __ __ __ __

1. Complaints Please tell us the main reason why you are here:__________________________________

   ____

   ____

2. Secondary Complaints Please let us know any other health concerns that you have: ________________________

   ____

   ____

3. Previous Treatments What previous treatment have you had for these?:__________________________________

   ____

   ____

4. Medications Please let us know all prescription medications you are taking:______________________

   ____

   ____

5. Major Illnesses — Please list any major illnesses and approximate dates:______________________________

____

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6. Surgeries — Please list any surgeries and approximate dates:____________________________________

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7. Injuries — Please list any accidents or injuries, and approximate dates:__________________________

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8. Women only

(Please circle your answers) Are you pregnant: Yes / No   Are you nursing? Yes / No

Date of onset of last menstrual period: ____________________________

Any gynecologic surgeries (hysterectomy, endometriosis, ovarian cysts)? __________________________

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Menstrual Cycle Do you have regular monthly periods (please circle) Yes / No
Circle any of the following symptoms you experience associated with your period:

Cramping Bloating Moody Cravings Heavy bleeding Back pain Headaches Clots

9. Sleep (please circle) Trouble falling asleep Can't stay asleep Bad dreams

Any other sleep problems? ____

10. Pets — Any pets? Yes / No If yes, what kind and how many?______________________________

11. Exercise What kind of exercise do you do?______________________________

How often?____________________ Duration?____________________

12. Food Allergies Please list: ______________________________________

____

13. Food Cravings For each question, check the choice that best describes your food craving, regardless of whether or not you let yourself eat these foods.

a. If you could have any breakfast that you wanted, which would you choose?

_______ Poached eggs with hollandaise sauce

_______ Bacon and eggs

_______ Granola and yoghurt

_______ Toast and oatmeal and coffee or tea

b. If you could have any lunch that you wanted, which would you choose?

_______ Barbecued ribs or teriyaki and chips

_______ Hamburger and French fries

_______ A cheese sandwich and/or a milkshake

_______ A sandwich, pretzels and a soda or coffee

c. If you could have any dinner that you wanted, which would you choose?

_______ Thai food

_______ A nice steak

_______ Pizza

_______ Pasta with sauce