BETTER LIVING Nutrition
...Caring for the whole you

Holistic wellness questionnaire

Thank you for taking the time to invest in your health and wellbeing.

Holistic nutrition is a rapidly growing area of healthcare that is based on the principles of balancing and harmonizing the whole body. This is done through diet and lifestyle changes specific to you.

Note: All the information gathered is completely confidential and will not be shared with any third parties.

Please be as candid and open as possible the get the most out of your session.

CLIENT INFORMATION

Full Name _____ Date of birth _____ (mm) _____ (dd) _____ (yyyy) Age_____

Primary phone _____ Email address _____

Cell phone _____ Work Phone _____

Emergency Contact _____ Phone (for emergency) _____

Marital status _____ Children? If yes, how many? _____

Occupation _____ Hours of work per day _____

Please enter your address:

No. & Street _____ Apt #, Unit #, PO Box # _____

City, Town _____ Province, State _____

Postal code _____ Country _____

MAIN HEALTH CONCERNS

Please list your main health concerns.

YOUR HEALTH HISTORY

List any and all diagnosis you have received for any health concern recently or in the past, as far back as childhood:

Are you seeing any other Healthcare practitioners:

Please check all that apply.

- ☐ Medical Doctor
- ☐ Dentist
- ☐ Naturopath
- ☐ Acupuncturist
- ☐ Psychiatrist
- ☐ Chiropractor
- ☐ Massage Therapist
- ☐ Osteopath
- ☐ Herbalist
- ☐ Homeopathic Doctor
- ☐ Chinese Medicine
- ☐ Other_____

List all of your current medications.

MEDICATIONS	DURATION	REASON / CONDITION

List all your current supplements (vitamins, minerals, herbs).

NATURAL HEALTH PRODUCT	DOSE	DURATION	REASON / CONDITION

List all health issues (diabetes, cancer high blood pressure etc.) of parents and siblings

Please check any symptoms or conditions you are **currently experiencing** or have experienced in the past:

- ☐ Headaches
- ☐ Itchy Eyes
- ☐ Skin Rash
- ☐ Brittle Nails
- ☐ White spots on nails
- ☐ Ridges on nails
- ☐ Dry Scalp
- ☐ Oily Skin
- ☐ Itchy skin
- ☐ Coated tongue
- ☐ Hay fever
- ☐ Runny Nose
- ☐ Red bumps on back of arms
- ☐ Dry Skin
- ☐ Root Canals
- ☐ Cold hands and feet
- ☐ Cracks in margins of lips
- ☐ Sore or burning tongue
- ☐ Frequent colds
- ☐ Wilson's Disease
- ☐ Hemolytic Anemia
- ☐ Decreased ability to taste
- ☐ Bleeding gums
- ☐ Organ Transplant
- ☐ Kidney Stones
- ☐ Sickle cell anemia
- ☐ Kidney failure
- ☐ Amalgam fillings

Do you shower or bath daily?	☐ Yes	☐ No	☐ Sometimes
Do you brush your teeth daily?	☐ Yes	☐ No	☐ Sometimes
Do you floss your teeth daily?	☐ Yes	☐ No	☐ Sometimes
Hours of sleep per night:	☐ 3—5	☐ 6—7	☐ 8—10+
Do you go to bed and get up at the same time each day?	☐ Yes	☐ No	☐ Sometimes
Do you wake up feeling rested?	☐ Yes	☐ No	☐ Sometimes
Do you exercise?	☐ Yes	☐ No	☐ Sometimes

If yes, indicate what you do and how often.

Do you drink caffeinated beverages? ☐ Yes ☐ No

If so, how many per day/week?

_____per day _____per week

_____ minutes.

Do you drink carbonated beverages? ☐ Yes ☐ No

If so, how many per day/week

_____ per day _____per week

Any diet drinks? ☐ Yes ☐ No

If yes List: e.g. coke:

If yes, list_____

Indicate your level of energy: (1 being low, 10 being high on an average day)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 LOW — 5 NORMAL — 10 HIGH

Does your energy change throughout the day? (write: **low, normal,** or **high** in the corresponding time slots)

6 a.m. - 9 a.m.	9 a.m. - Noon	Noon - 3 p.m.	3 p.m.	4 p.m. - 6 p.m.	6 p.m. - bedtime

Do you have any known allergies or suspected food intolerances. List all.

Check all digestive concerns you experience either now or have in the past.

☐ Bloating ☐ Gas ☐ Cramping

☐ Constipation ☐ Loose Stools ☐ Diarrhea

☐ Heartburn ☐ Indigestion ☐ Burping

How many bowel movements do you have a day? 0 ☐ 1 ☐ 2+ ☐

How many times a day do you eat? Main meals_____ Snacks_____

What time of day is your last Meal?_____ Snack?_____

Do you skip meals? Yes ☐ No ☐ If you skip a meal do ☐ irritable ☐ weak ☐ lightheaded

How long does it usually take you to eat?_____ minutes

Do you usually consume a beverage with your meal? (water, juice, coffee, tea, etc.) ☐ Yes ☐ No

Please list any food aversions and/or foods you dislike:

_____

_____

_____

Do you have any cravings? Please check all.

☐ sweets/desserts ☐ chocolate ☐ sodas

☐ fried foods ☐ peanuts ☐ bread/pasta

☐ alcoholic drinks ☐ meat ☐ fish

☐ cheese ☐ Other_____

List the top 5 foods you eat the most often.

1 _____ 4 _____

2 _____ 5 _____

3 _____

Do you have any dietary restrictions?
For example: no red meat, vegan, vegetarian, no milk, etc. **Please be very specific**

Are there any foods you are not willing to give up?

Is there any particular food you feel addicted to?

Do you consume alcohol?
☐ Yes ☐ No
If yes, how much and how often?

Do you smoke?
☐ Yes ☐ No
If yes, how much and how often?

Do you use recreational drugs?
☐ Yes ☐ No
If yes, how much and how often and what type?

Do you use cream in your coffee or tea? ☐ Yes ☐ No ☐ Sometimes

Do you routinely use butter on bread products such as toast, bagels, etc? ☐ Yes ☐ No ☐ Sometimes

Do you routinely use butter for cooking or on baked potatoes or vegetables? ☐ Yes ☐ No ☐ Sometimes

Do you use regular sour cream or high fat salad dressings More than once a week (i.e. French, Thousand Island)? ☐ Yes ☐ No ☐ Sometimes

Which oils (fats) do you use when cooking, or consume on a regular basis? Please circle all that apply.

butter	margarine	olive oil	coconut oil
flax oil	sesame oil	peanut oil	corn oil
Soybean oil	canola oil	sunflower oil	mayonnaise

How many glasses of water do you drink a day? _____ (8 oz.)

What is your source of water? Please circle all that apply:

Filtered Tap Reverse Osmosis Spring Bottled Other _____

How many **fruits** do you eat per day?_____

1 serving = 1 apple, etc.

How many **vegetables** do you eat per day?_____

1 serving = 1 cup broccoli, etc.

Are the fruits and vegetables organic? ☐ Yes ☐ No ☐ Sometimes

Describe your relationship with food:
Excellent, good, poor, food is your enemy.
Please be very specific.

WOMEN ONLY— YOUR REPRODUCTIVE HEALTH

Do you have a healthy sex drive? ☐ Yes ☐ No
If not, when was the last time you can
Remember having one?

At what age did you reach puberty? _____

Do you have any hormonal issues that you
are aware of? If so, please explain.

Please check any symptoms of **PMS** (pre-menstrual syndrome)
☐ Cramping ☐ Bloating ☐ Headaches
☐ Change in mood ☐ Breast tenderness ☐ Irritability

Please check any symptoms of **menopause** you experience.
☐ Hot Flashes ☐ Cravings ☐ Headaches
☐ Change in mood ☐ Weight gain ☐ Irritability

Do you experience **emotional upset** at the same time each month?
If so, be specific—depression, anxiety, nervousness, excitability, extreme emotions.

How often do you have a menstrual cycle? _____ year. I no longer have a have a menstrual cycle as of _____

Are you on birth control or have you ever been? ☐ Yes ☐ No If yes, how many months/years?
_____months _____years

Are you on any form of hormone replacement? Synthetic or natural? ☐ Yes ☐ No If yes, how many months/years?
_____months _____years?

Have you had a miscarriage? ☐ Yes ☐ No If yes, how many times?_____

Have you given birth? ☐ Yes ☐ No If yes, how many? _____

Have you had an abortion? ☐ Yes ☐ No If yes, how many? _____

Have you had any fertility treatments ☐ Yes ☐ No Describe:_____

MEN ONLY— YOUR REPRODUCTIVE HEALTH

Do you have any of these conditions?
Please check all that apply.

- ☐ Frequent urination
- ☐ Difficulty urinating
- ☐ Night urination
- ☐ Pain in groin
- ☐ Enlarged prostate
- ☐ Painful intercourse
- ☐ Sore genitals
- ☐ Discharge from genitals
- ☐ Erection difficulties
- ☐ Unviable sperm/fertility
- ☐ Prostate cancer

Prescribed Tx for cancer:

When diagnosed?_____

YOUR EMOTIONAL HEALTH

Has there been any significant emotional trauma in your life? Divorce, separation, family problems, death of someone close, abuse, etc.
Please describe.

Do you tend to eat MORE or LESS when stressed? _____

Do you spend time relaxing every day? ☐ Yes ☐ No

Describe your purpose in life. What do you get out of bed for?

Do you actively participate in a church or spiritual group?

☐ Yes ☐ No

Indicate your stress level: (1 being low, 10 being high on an average day)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 5 10

List the source(s) of your stress. **Please be specific.**

What is your method of coping with stress?

Do you go on regular vacations? ☐ Yes ☐ No ☐ Sometimes

Are your relationships healthy & fulfilling? ☐ Yes ☐ No ☐ Sometimes

Do you every eat for emotional reasons? ☐ Yes ☐ No ☐ Sometimes

Do you binge eat at times? ☐ Yes ☐ No ☐ Sometimes

Do you have or have you ever had an eating disorder?
Either under-eating or over-eating? **Please explain.**

YOUR ENVIRONMENTAL HEALTH

Do you **use** or **consume** any of the following? Please check all that apply.

- ☐ Insecticides
- ☐ Pesticides
- ☐ Regular cleaning supplies in your home
- ☐ Store food in plastic containers
- ☐ Regular Laundry Soap
- ☐ Chlorinated bleach
- ☐ Air fresheners
- ☐ Tin Foil
- ☐ Artificial sweeteners
- ☐ Use organic meat
- ☐ Frequently fly in air planes
- ☐ Sleeping Pills
- ☐ Antidepressants
- ☐ Levodopa
- ☐ Anti-convulsants
- ☐ Food from tin cans
- ☐ Aluminum cookware
- ☐ Heat food in plastic containers
- ☐ Heat food with plastic wrap on it
- ☐ Use a Gas Stove
- ☐ Microwave Oven
- ☐ Consume organ meats
- ☐ Laxatives
- ☐ Diuretics
- ☐ Digoxin
- ☐ Indomethacin
- ☐ Amphetamines
- ☐ Statin drugs
- ☐ Prednisone
- ☐ Cortisone
- ☐ Regular hand lotion
- ☐ Nail Polish
- ☐ Shower or bath in chlorinated water
- ☐ Eat fresh and salt water fish and shellfish
- ☐ Scented body products
- ☐ Nail Polish remover
- ☐ Cosmetics
- ☐ Anti-perspirant
- ☐ Regular soaps
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Naproxen
- ☐ Beta blockers
- ☐ Captopril (for HBP)
- ☐ Antacids

Is your garage attached to your house? ☐ Yes ☐ No

Are cans of paint stored anywhere in your home? ☐ Yes ☐ No

Are other chemicals such as pesticides stored in your house? ☐ Yes ☐ No

Do you work in an energy efficient or air-tight building? ☐ Yes ☐ No

Do you live under or near high power lines? ☐ Yes ☐ No

Do you sleep under an electric blanket? ☐ Yes ☐ No

Do you use a blow dryer to dry your hair? ☐ Yes ☐ No

Do you work at or frequently use a computer video display monitor? ☐ Yes ☐ No

If yes, how many hours a day would you be in front of a screen? _____hours Are you sitting or standing?_____

Do you talk on the cell phone? ☐ Yes ☐ No

If yes what is the amount of time per day you would be on the phone per day? _____minutes

Where do you usually carry your cell phone? _____

YOUR NUTRITIONAL EXPECTATIONS

What are you expecting from your nutrition program?

How do you think your nutrition program will affect your daily life?

Have you tried any nutrition programs or diets in the past to reach your goals, and were you successful?

How would you rate your nutrition in these areas: **poor** **needs improvement** **good** or **excellent**

Scheduling/planning: _____

Balancing carbs, fat, protein ratios: _____

Level of commitment to a program: _____

Please include anything else you want to cover in your nutrition session:

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

I look forward to helping you achieve your finest health ever!

For Office use only

Bone Size S M L XL

Height _____ft_____in

Blood Pressure _____/_____

Weight _____lbs

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BETTER LIVING Nutrition
...Caring for the whole you

Service agreement

This agreement is between, GLENDA NISCHUK, OWNER OF BETTER LIVING NUTRITION and

_____ _____

First Name Last Name

Terms & Conditions

ACCEPTANCE OF SERVICES

I, "Client" take full responsibility for my health, healing and progress on my nutrition plan. I acknowledge change can take time and I am ready for a plan that is not about fad diets or quick-fixes but about smaller changes over time leading to sustainable change.

CONFIDENTIALITY

All information shared within the professional relationship will be held with the strictest confidence. We will only share your information at your request and with your consent. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols.

SCHEDULING & CENCELLATION

Please do everything possible to keep your appointment as this time is reserved just for you. If you are unable to keep your appointment, please give us at least 24 hours notice so we may schedule another time for you. Thank-you.
Please note: Habitually missed appointments with no notification will be billed in full.

PAYMENT POLICY

Payments are due in full upon receipt of invoice and/or after session. Payment can be made via cash,
Debit, Visa, Master card or cheque made payable to Better Living Nutrition.

☐ *By submitting this form to Better Living Nutrition, I fully understand and agree with the terms and conditions outlines above.*

Date _____ _____ _____

mm dd yyyy

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