Client Information Form

Name: _____ Sex: M F Today's Date: _____

Mailing Address: _____City_____Zip_____

Home Phone: _____ E-mail Address: _____

Cell Phone: _____ Referred By: _____

Height: _____ Weight: _____ Blood Type: _____ Birth Date: _____ Age _____

Nutrition & Dietary Information

Please circle anything that applies to your eating habits and fill in the blanks:
(1 = Eaten Daily; 2 = Weekly; 3 = Occasionally; 4 = Never) If there is a choice in items—<u>circle the items that apply</u>:

Pork or Shellfish	1 2 3 4	Caffeine (coffee, soda or tea): I drink ____ cups each (day, week, month)
Red Meat	1 2 3 4	Soda Pop: I drink ____ ounces each (day, week, month)
Chicken or Turkey	1 2 3 4	I use (refined sugar, raw sugar, stevia, xylitol, _____) as a sweetener
Eggs (1, 2 or 3 at a meal)	1 2 3 4	I use (white flour, wheat flour, _____)
Dairy – I drink ____ cups	1 2 3 4	Typical Breakfast: _____
Cheese, Yogurt, Ice Cream	1 2 3 4	Typical Lunch: _____
Fried Foods	1 2 3 4	Typical Dinner: _____
Fresh Vegetables (___) servings per)	1 2 3 4	I eat out _____ meals per week
Fresh Fruits (____) servings per)	1 2 3 4	I eat breakfast (every day, most days, rarely, or never) I eat lunch (every day, most days, rarely, or never)
Whole Grains	1 2 3 4	I eat dinner (every day, most days, rare, or never)
Fresh Fish	1 2 3 4	Alcohol: (every day, most days, rarely, or never)
Sweets	1 2 3 4	Drink of choice is _____
Water	1 2 3 4	My snack preference is: _____

Lifestyle Information

Who lives with you (people & pets)?: _____.

How much sleep do you get each night (on average)? _____ hours. Describe your sleep: _____.

What is your energy level like? _____.

Where would you say your stress is greatest? _____.

How often do you exercise? ____ hours per _____. Describe the type of exercise you do: _____.

Do you work (paid or unpaid)? _____ What is your job?: _____. How long is your drive time each day? _____.

How many hours a day/week do you work? _____. Most of the time I _____ my job.

During the day I take time to (circle all that apply): Meditate, take breaks, stretch, walk, read, socialize, other _____.

For relaxation I _____( ) hours per day.

Things that <u>stress me out</u> are: _____.

If you use tobacco, how often per day? _____ (smoke, chew, snuff); (cigars, pipe cigarettes or chewing tobacco; marijuana).N/A _____

Each day I (circle which applies): Journal; read inspirational books; listen to or watch positive thinking based media; or _____

Health History/Information

List any nutritional supplements you take: _____

_____

List the problems/conditions/diagnosis	Which medication are you taking for it?	List any other treatment/therapy you are doing

List any serious illnesses or surgeries you have had in the past (not affecting you today): _____

_____

What would you like help with today (please try to list in order of importance)?

_____

_____

_____

I have seen the following for the above concern(s): Medical Doctor; Chiropractor; Therapist (Massage, physical or mental/emotional)

How many bowel movements do you have each day? _____. Are they (circle all that apply) natural, forced, hard, watery?

How many ounces of water (not tea, energy drinks or vitamin water) do you drink per day? _____

What type of water do you drink--bottled, tap, purified by reverse osmosis, filtered, distilled or alkaline water.

List any other information you think might be helpful:

I fully understand that Jackie Stevens is a Certified Natural Health Consultant; and is not a medical doctor, and therefore does not treat disease nor prescribe medicine for any conditions.

☐ I would like as much information about my concern as possible.
☐ I would like to know how I can help other people by learning more.
☐ I would like to have a guest speaker for my group.

Signature: _____ Date: _____

Services provided by Jackie Stevens, CNHC

Please check what you are interested in:

☐ Emotional Healing work
☐ Flower Essence Therapy
☐ Muscle Response Testing
☐ Aromatherapy
☐ DermaGrid Scan
☐ Nutritional Consulting
☐ Healthy Habits Classes
☐ Ear Candling

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