Welcome to Zawada Health, where the health of you and your family is our priority.

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

NOTE: All of the information gathered is completely confidential so please be as candid and open as possible to get the most out of your appointment.

CLIENT INFORMATION

Full Name ______________________ Date of birth ____ ____ ____
MM DD YYYY

Primary phone ______________________ Email address ______________________

Address:

____

Occupation ______________________

How did you hear about us? ______________________

MAIN HEALTH CONCERNS

Please list your TOP 5 health concerns in order of importance.

1
2
3
4
5

HEALTH HISTORY

Are you working with any other healthcare practitioners? **Please check all that apply.**

- ☐ Medical Doctor
- ☐ Naturopath
- ☐ Homeopath
- ☐ Acupuncturist
- ☐ Psychiatrist
- ☐ Chiropractor
- ☐ Massage Therapist
- ☐ Osteopath
- ☐ Herbalist
- ☐ Dentist
- ☐ Other

List all your current medications.

MEDICATIONS	DURATION	REASON/CONDITION

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

SUPPLEMENTS	DOSE	DURATION	REASON/CONDITION

Have you ever experienced an allergic or adverse reaction to any of the medications or supplements listed above? If yes, please explain.

Please list all major health concerns (diabetes, cancer, high blood pressure etc.) of immediate family.

	HEALTH CONCERNS	AGE
MOTHER		
FATHER		
SISTER		
BROTHER		
GRANDPARENTS		

Please list any and all symptoms you are currently experiencing.

DESCRIPTION OF SYMPTOM	ALWAYS HAPPENS WHEN?	I FEEL RELIEF IF?

Have you ever been hospitalized? If so, please explain.

____

Weight: ______________ Max Weight: _____________ When? ______________

Do you have or have you ever had an eating disorder? **Please explain.**

Hours of sleep per night ☐ 3 - 5 ☐ 6 - 7 ☐ 8 - 10+

Do you wake up feeling rested? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

If yes, what you do and how often?

Do you drink caffeinated beverages? ☐ Yes ☐ No

If so, how many per day/week? ______ per day ______ per week

Do you drink carbonated beverages? ☐ Yes ☐ No

If so, how many per day/week? ______ per day ______ per week

Any diet drinks? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No

If so, how many per day/week? ______ per day ______ per week

How many glasses of water do you drink per day? ______

Indicate your level of energy: (1 being low, 10 being high)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 LOW — 5 NORMAL — 10 HIGH

Do you notice a change of energy throughout the day? (Write: **low**, **normal**, or **high** in the corresponding time slots)

______	______	______	______	______	______
6 am - 9 am	9 am - Noon	Noon – 3 pm	3 pm – 6 pm	6 pm – 9 pm	9 pm - bedtime

Do you have any known allergies or food intolerances? Please list all.

Please check all digestive issues you are experience.

- [ ] Bloating
- [ ] Gas
- [ ] Cramping
- [ ] Constipation
- [ ] Loose stools
- [ ] Diarrhea
- [ ] Heartburn
- [ ] Indigestion

How many bowel movements do you have a day?

- [ ] 0
- [ ] 1
- [ ] 2+

Do you suffer from food cravings?
If so, please list all.

TOP 5 foods you eat the most often.

1 ______

2 ______

3 ______

4 ______

5 ______

Do you have any dietary restrictions?
(gluten-free, vegan, vegetarian, dairy free)

Are there any foods you would have a hard time giving up?

Are there any foods you feel addicted to?

How many servings of **fruit** do you eat per day? 1 serving = 1 apple. Which fruits do you eat most?

How many servings of **vegetables** do you eat per day? 1 serving = 1 cup of broccoli. Which vegetables do you eat most?

Do you only buy organic?

☐ Yes ☐ No ☐ Sometimes

Describe your relationship with food:
(Excellent, good, food is my enemy)
Why do you feel this way?

How often do you eat meat during the week? If so, what type?

How often do you eat fish during the week? If so, what type and is it canned, fresh or farmed?

How many times a week do you eat at a restaurant? If so, where do you like to go?

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

Has there been any significant emotional stress in your life that has made an impact on your health? (Divorce, separation, death, abuse)

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

Indicate your level of stress: (1 being low, 10 being high)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1	5	10
LOW	NORMAL	HIGH

What are the sources of stress in your life?
Please be specific.

What is your method of coping with stress?

MEN'S HEALTH

Please check any that you are experiencing.

- ☐ Hernia
- ☐ Low Sex Drive
- ☐ Headaches
- ☐ Testicular Pain
- ☐ Cravings
- ☐ Irritability

When was your last prostate Exam? ____________

WOMEN'S HEALTH

Please check any symptoms of **PMS** you experience.

- ☐ 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.

Are you on the birth control? ☐ Yes ☐ No If yes, how many months/years?

_____ Months _____ Years

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

_____ Months _____ Years

Have you ever given birth? ☐ Yes ☐ No

Have you ever had a miscarriage? ☐ Yes ☐ No

Have you ever had an abortion? ☐ Yes ☐ No

Have you had any fertility treatments? ☐ Yes ☐ No

If yes, please list?

EXPECTATIONS

What are you expecting from this appointment?

How do you think addressing your nutrition will affect your health?

Have you tried any diets in the past to reach your health goals? If so, please explain.

How would you rate you nutrition? ☐ Good ☐ Fair ☐ Bad

Balancing your: Protein / Fat / Carbs? ☐ Good ☐ Fair ☐ Bad

What is your level of commitment? ☐ Ready to do the work ☐ Scared of failure

Is there anything you feel is important to note that has not been covered in this questionnaire?

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE.

I look forward to working with you!

Service Agreement

This agreement is between, ALEXIS NILSEN and

First Name ______________________ Last Name ______________________

Terms & Conditions

ACCEPTANCE OF SERVICE

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 lifestyle and dietary changes that over time will improve my health and overall health.

CONFIDENTIALITY

All information shared within the professional relationship will be held with the strictest confidence. Information may be shared at the client's request with a medical doctor, naturopathic physician or any other healthcare practitioner the client deems appropriate.

SCHEDULING & CANCELLATION POLICY

Rescheduled or cancelled appointments with less than 24 hours notice will be billed in full. All fees are non-refundable, non-transferable.

☐ *By submitting this form to Zawada Health, I fully understand and agree with the terms and conditions outlined above.*

Date ______ ______ ______
MM DD YYYY

Signature ______________________