Client Assessment Questionnaire

DEMOGRAPHIC DATA

Name _____Date: _____

Address _____

Home telephone: _____Cell telephone: _____

Email _____Sex: M F Age: _____

Birthdate _____ Height _____ Weight_____

HEALTH HISTORY

1. What medical concerns (e.g., pregnancy), if any, do you have at the present time?

_____

_____

2. Indicate if you have had blood relatives with any of the following problems:

Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	Thyroid disorder	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No			

3. Do you have complaints about any of the following?

_____ Appetite	_____ Constipation	_____ Menstrual Difficulties
_____ Bleeding Gums	_____ Diarrhea	_____ Difficulty Seeing
_____ Bruising	_____ Edema	_____ Sudden Weight Change
_____ Chewing	_____ Swallowing	_____ Stress
_____Indigestion		

4. Do you use tobacco in any way? ☐ Yes ☐ No
How much? _____

Did you recently stop smoking? ☐ Yes ☐ No

5. Do you enjoy physical activity? ☐ Yes ☐ No Explain_____

6. List any food allergies or intolerances.

DRUG HISTORY

List any prescribed, over-the-counter, herbal, or vitamin/mineral supplements you take.

_____

_____

DIET HISTORY

1. Do you follow a special dietary plan, such as, low cholesterol, kosher, vegetarian?

_____

2. Have you ever followed a special diet? _____ Explain _____

3. Do you have any problems purchasing foods that you want to buy? _____

4. Are there certain foods that you do not eat? _____

5. Do you eat at regular times each day? ☐ Yes ☐ No How often? _____

6. Identify any foods you particularly like. _____

7. Do you drink alcohol? ☐ Yes ☐ No How often? _____

8. What change would you like to make?

- ☐ Improve my eating habits
- ☐ Improve my activity level
- ☐ Learn to manage my weigh
- ☐ Improve my cholesterol/triglyceride levels
- ☐ Other _____

9. Please add any additional information you feel may be relevant to understanding your nutritional health._____

_____

10. In order to tailor your counseling experience to your needs, it would be useful to know your expectations. Please check one of the following to indicate the amount of structure you believe meets your needs:

☐ Tell me exactly what to eat for all my meals and snacks. I want a detailed food plan. Example: ½ cup oatmeal, 1 cup skim milk, 6 oz. orange juice, 1 slice whole wheat toast, 1 teaspoon margarine

☐ I want some structure and freedom to select foods. I want to use a food group plan. Example: 1 serving of dairy foods, fruits, and fat and oil group; 2 servings of grains

☐ I don't want a diet. I just want to eat better. I will just set food goals.

SOCIOECONOMIC HISTORY

1. What is the highest level of formal education you received? _____

Other type of school _____

2. Are you employed? _____ Occupation _____

3. How many people in your household? _____ Ages? _____

4. Present marital status (circle one):

Single Married Divorced Widowed Separated Engaged

5. Do you have a refrigerator? _____ Stove? _____

6. Who prepares most of the meals in your home? _____ Who shops? _____

7. Do you use convenience foods daily? ☐ Yes ☐ No

8. How often do you eat out? _____ Where? _____

9. Have you made any food changes in your life you feel good about? ☐ Yes ☐ No

10. Who could support and encourage you to make these changes? _____

_____

EDUCATION INTERESTS

What information would you like from your counselor?

☐ Grocery Store Shopping Tour	☐ Eating Out	☐ Exercise
☐ Weight Management	☐ Portion Size	☐ Supplements
☐ Healthy Food Preparation	☐ Eating Less Fat	☐ Meal Planning
☐ Snack foods	☐ Food labels	☐ Other

Is there anything else you would like me to know about? _____

_____

_____

_____

Thank you for your willingness to share this information. I look forward to working with you to make lifestyle changes to meet your goals.

Voula Cicchelli, CSNP, CHN, RNCP
Holistic Nutrition Practitioner and Fitness Coach

PLEASE EMAIL COMPLETED FORMS to voula@lifestyle4life.com