# Health Journeys Client Health Questionnaire

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| --- | --- | --- | --- |
| Name  |  | Date  |  |
| Address |  |
|  |
|  |
| Occupation |  | Marital Status |  |
|  |  |  |  |
| Mobile Ph. |  | Home Ph. |  |
| Email |  |
|  |
|  |
| What is your main reason for consulting us?  |
|  |
|  |
|  |
| Do you have any other health issues? |
|  |
|  |
| Are you aware of any food or other allergies? |
|  |
| Do you have hereditary health concerns? |
|  |
| Current medications (and duration of use) |
|  |
| Current supplements or herbal medicine |
|  |
|  |
|  |
|  |
| Please rate from one to ten with ten being optimal: |
| Energy levels: |
| Morning: |  | Afternoon: |  | Evening: |  |
|  |
| Current Stress Levels: |
|  |
| Current Emotional Wellbeing: |
|  |

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| --- | --- | --- | --- | --- | --- |
| **Do you often get:****(Please put ‘Y’ in correct box)** | Never | In the past | On occasion | Often | Further information |
| Digestion | Bloating after meals |  |  |  |  |  |
|  | Excessive flatulence |  |  |  |  |  |
|  | Constipation |  |  |  |  |  |
|  | Diarrhoea  |  |  |  |  |  |
|  | Heart burn/ reflux |  |  |  |  |  |
|  | Nausea/ vomiting |  |  |  |  |  |
|  | Indigestion |  |  |  |  |  |
|  | Undigested food in stools |  |  |  |  |  |
|  | Abdominal pain |  |  |  |  |  |
|  | Bad breath |  |  |  |  |  |
|  | Anal itching |  |  |  |  |  |
| Respiratory  | Asthma |  |  |  |  |  |
|  | Hay fever |  |  |  |  |  |
|  | Cold/ coughs in winter |  |  |  |  |  |
|  | Sinus infections |  |  |  |  |  |
|  | Ear infections |  |  |  |  |  |
|  | Sore throat |  |  |  |  |  |
| Cardiovascular | High blood pressure |  |  |  |  |  |
|  | Varicose veins |  |  |  |  |  |
|  | Cold hands and feet |  |  |  |  |  |
|  | Raised cholesterol |  |  |  |  |  |
| Urinary | Pain in urination |  |  |  |  |  |
|  | Urinary tract infections |  |  |  |  |  |
|  | Hesitancy/ dribbling/ urgency |  |  |  |  |  |
|  | Incontinence |  |  |  |  |  |
| Reproductive  | PMS (anger, sadness, anxiety) |  |  |  |  |  |
|  (Female) | Erratic cycle |  |  |  |  |  |
|  | Heavy periods |  |  |  |  |  |
|  | Painful periods |  |  |  |  |  |
|  | Breast tenderness |  |  |  |  |  |
|  | Fluid retention |  |  |  |  |  |
|  | Ovulation pain |  |  |  |  |  |
| (Male) | Erectile difficulties |  |  |  |  |  |
| Skin | Eczema  |  |  |  |  |  |
|  | Psoriasis |  |  |  |  |  |
|  | Dryness |  |  |  |  |  |
|  | Oily skin |  |  |  |  |  |
|  | Itchiness |  |  |  |  |  |
| Nervous system | Anxiety |  |  |  |  |  |
|  | Depression |  |  |  |  |  |
|  | Heart palpitations |  |  |  |  |  |
|  | Low mood/flatness |  |  |  |  |  |
|  | Mood swings |  |  |  |  |  |
| Musculoskeletal | Joint/ muscle pain |  |  |  |  |  |
|  | Leg cramps |  |  |  |  |  |
|  | Headaches |  |  |  |  |  |
|  | Migraines |  |  |  |  |  |
| Sleep | Difficulty falling asleep |  |  |  |  |  |
|  | Waking in the night |  |  |  |  |  |
|  | Waking unrefreshed |  |  |  |  |  |

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|  |
| **Nutrition:** |
| Do you eat at regular times daily? |
|  |
| What is your favorite food? |
|  |
| Do you enjoy eating with others?  |
|  |
| Do you eat when hungry? |
|  |
| Do you tend to overeat? |
|  |
| Do you often get lightheaded before eating? |
|  |
| Do you eat any organic foods?  |
|  |
| Do you have any food sensitivities/ allergies? |
|  |
| Are you hungry at breakfast time? |
|  |
| Do you ever eat ‘on the run’ and when?  |
|  |
| Do you get any discomfort after eating fruit? |
|  |
| **Lifestyle:** |
| What do you enjoy to do when you are not working? |
|  |
| What stresses you most in your life? |
|  |
| What (if any) exercise do you do? |
|  |
| Are you social or more self-dependent? |
|  |
| What would you most wish to achieve in your health?  |
|  |

**Thank you for completing the questionnaire.
Please save the completed questionnaire and send to** **healthjourneysnz@gmail.com** **at least one day prior to your appointment.**