*Juliana's Nutrition & Wellness Services*
*(within)*
**Perfect Balance**
Wellness Centre
125 Bedford Road • Kitchener, ON N2G 3A3

# CLIENT INFORMATION & HEALTH HISTORY

**Client Information** (please print clearly)

Name: _____ Date of Birth: (mm/dd/yyyy) ____/____/_____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (B) _____ (M) _____

Email: _____

Occupation: _____ Who referred you? _____

Approximate Weight: _____ Approximate Height _____

What other practitioner are you currently seeing:

❑ Naturopath ❑ Osteopath ❑ RMT ❑ Chiropractor ❑ Homeopath ❑ Other: _____

**Health History**

What are your major health concerns / goals for coming in today? _____

Current Medications & Supplements (conditions they target): _____

Do or have you taken birth control pills? ❑ Yes ❑ No ❑ N/A

Motor Vehicle Accident? ❑ Yes ❑ No Date: _____

Other Accident(s)?: _____

Have you taken antibiotics in the last 5 years? ❑ Yes ❑ No

Do you have any allergies or sensativities? ❑ Yes ❑ No

(If Yes, Please list all) _____

Have you been diagnosed with any health conditions? Any surgeries?

_____

Family History (please list):

_____

Do you wish to gain or lose weight? If so, how much: _____ By when? _____

If yes, what is your motivation to change your weight? _____

How many bowel movements do you have a day? What time(s)? _____

Do you suffer from diarrhea or constipation? If yes, can you correlate to food or emotions?

_____

Do you consume any of the below? If yes, mark O for often and R for rarely:

| | | | | | |
|---|---|---|---|---|---|
| Carbonated drinks | | Caffeinated drinks | | Margarine | |
| Regular pop | | Alcohol | | Deli meats | |
| Diet pop | | Fluids with meals | | Candy/chocolate | |
| Milk | | Fast food | | Microwaved meals | |

What foods do you love? _____

What foods do you dislike? _____

Any foods/drinks you are not willing to give up? _____

Do you have any food restrictions (vegan, religious, etc) _____

How much water do you drink a day and type (tap, bottled, RO, solid carbon): _____

How many meals you consume a day and times? _____

Do you cook your own meals? If so, how often: _____

List a typical meal day:

| **Time** | **Meal** | **Describe** |
|---|---|---|
| | Breakfast | |
| | Lunch | |
| | Dinner | |
| | Snacks | |

Please mark any that apply:

| | | Rarely | Occasionally | Frequently |
|---|---|---|---|---|
| **EATING & DIGESTIVE HEALTH** | Binge eating | ☐ | ☐ | ☐ |
| | Guilt after meals | ☐ | ☐ | ☐ |
| | Bloating/ gas | ☐ | ☐ | ☐ |
| | Heartburns | ☐ | ☐ | ☐ |
| | Indigestion | ☐ | ☐ | ☐ |
| | Quick chewing | ☐ | ☐ | ☐ |
| | Nausea/vomiting | ☐ | ☐ | ☐ |
| | Abdominal pain | ☐ | ☐ | ☐ |
| | Bleeding/strains | ☐ | ☐ | ☐ |

How many hours do you sleep per night? _____ Do you wake up rested? _____

What time do you go to bed? _____ Do you snooze in the morning? _____

Do you wake up during the night? _____ If yes, why and how often? _____

(FEMALES)

Are you pregnant or could be pregnant? _____ Do you have kids? _____

Are you pre-menopause? _____ If yes, any issues with your period: _____

Are you in menopause? If yes, for how long and any symptoms? _____

(MALES)

Have you seen changes in libido? _____ Do you urinate frequently? _____

Do you need to wake up at night to urinate? _____ Do you get your prostate checked regularly? _____

Have you experienced any major trauma (physical or emotional) in the last 5 years? If yes, please list: _____

How would you rate your current stress levels:

Extremely stressed  Very stressed  Somewhat stressed  A little stressed  Not stressed

What are the major causes of your stress, if any:

____ finances  ____ family  ____ career  ____ spouse  ____ health  Other:_____

Do you have any coping mechanisms for stress? Do you eat more or less when stressed?

_____

Are you fulfilled with your occupation? _____

Do you exercise? If so, describe type and frequency: _____

How would you rate your energy levels?

____ Lots of energy  ____ Average  ____ Low energy  ____ No energy

Any lulls or highs in your energy during the day? If so what time(s): _____

On an average day, how many hours do you spend:

Driving _____  Watching TV _____  Reading _____  Online _____ Fun activities _____

Do you vacation regularly? If so, where do you travel to? _____

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# Juliana's Nutrition & Wellness Services
# Client Consent Form

*Please print and sign after reviewing it thoroughly*

I, realize a Certified Holistic Nutritionist is not a medical doctor and cannot prescribe, diagnose or treat any specific diseases. The various strategies offered are designed to relieve stress, provide tools for a balanced eating program and guidance to promote a more active lifestyle. I, the undersigned, being of sound mind and exercising my freedom of choice, do willingly desire the holistic therapies offered, in keeping with the Health Care Consent Act (1996). I understand that an assessment is required to determine the best strategies to help me meet my goals. I am aware that all information provided is private and confidential and will not be released without a written consent. I agree to communicate with my practitioner should I have any questions or concerns. I understand and I am aware of the posted fees and cancellation policy. I am also aware the clinic is not responsible for any lost, stolen or damaged articles.

_____ _____

Client Name (please print) Current Address

_____ _____

Client Signature Date

CANCELLATION POLICY – we require 24 hours notice if you are unable to make your scheduled appointment. After one initial warning, all subsequent missed appointments will be billed at the regular fee.

Do you wish to subscribe to Naturally Joyous' newsletter?

- ☐ Yes please!
- ☐ No, thank you!