GIGI SITON, DPT
Self Healing

INITIAL INTERVIEW: CONFIDENTIAL CLIENT HEALTH QUESTIONNAIRE

Consultation Date: _____ Consultation Time: _____

** All of your personal information will remain strictly confidential! **

Name: _____

Email Address: _____

Street Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Work/Cell Phone: _____

Date of Birth: _____ Place of Birth: _____

Age: _____ Gender: _____ Height: _____ Current Weight: _____

Would you like your weight to be different? _____ If so, what? _____

Occupation: _____ How many hours do you work per week? _____

Relationship Status: _____ Children? _____

Blood Type (if known) _____ Referred by _____

Hobbies/Activities: _____

What are your health concerns? _____

_____

_____

_____

What would you like to accomplish/gain from this consultation? _____

_____

Do you sleep well? _____ Do you wake up during the night? _____

If so, what time(s)? _____ What time do you go to bed? _____

What time do you generally wake-up? _____

How do you feel when you wake up? _____

Do you drink caffeinated drinks? _____ How much and how often? _____

Do you smoke? _____ How much and how often? _____

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If no, why, how and when did you quit smoking? _____

Exposure to Secondhand Smoke? _____ If so, how and how long? _____

Do you drink alcohol? _____ How much and how often? _____

Do you drink soda (diet or regular)? _____ How much and how often? _____

What role does exercise play in your life? _____

Have you been exposed to toxic substances at work or home? _____

How much water do you drink per day? _____

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/non-prescription medications, aspirin, laxatives, diet pills, or any other supplements? Please list all below including name brands and amounts:

_____

_____

_____

_____

Do you have any known allergies to medications or herbs? _____ Please list all: _____

_____

_____

Are you currently under a practitioner's care for specific health issue? _____

If so, what treatments are you undergoing? _____

_____

_____

Please list any surgeries, accidents, injuries, or childhood diseases you have had along with the type and date: _____

_____

_____

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What were your eating habits like as a child? (List types of food) _____

_____

_____

What percentage of your food is home cooked? _____

How often do you eat out? _____

What are the three worst foods you eat each week? _____

_____

What are the three healthiest foods you eat each week? _____

_____

Do you crave sugar? _____ Do you crave salt? _____

Do you feel tired, bloated, and/or gassy after meals? _____

Do you experience constipation or diarrhea often? _____

When and how often? _____

_____

Do you feel excessively hungry? _____ Do you have a poor appetite? _____

_____

Family Health History (Indicate Yes with a check mark)

Diabetes		Kidney disease		Asthma	
Heart Disease		Arthritis		Gallbladder disease	

Cancer		Type of Cancer	
Stomach/Intestinal disorders		Other	

Mother Age		Died from	
Father Age		Died from	
Maternal Grandmother Age		Died from	

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Paternal Grandmother Age		Died from	
Maternal Grandfather Age		Died from	
Paternal /Grandfather Age		Died from	

WOMEN ONLY:

Age of your first period _____ Are your periods regular? _____

How frequent? _____ # of pregnancies _____

How many days is your flow? _____

Do you experience PMS? _____ Is it mild or severe? _____

Are you peri-menopausal? _____ When did this change first occur? _____

Are you menopausal? _____ When was your last period? _____

List your symptoms of peri/menopause: _____

_____

_____

How many children have you delivered and how were they born (vaginally or by caesarean)? _____

_____

_____

Were there complications associated with these births? _____

_____

_____

Did you receive antibiotics during labor? _____

Have you ever had a miscarriage or an abortion? _____ How many? _____

_____

MALE ONLY

Approximate age of onset of puberty _____ # of Children_____

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Do you feel your libido is adequate? Y N Comments: _____

Do you wake at night to urinate? _____ How many times per night? _____

Do you have any difficulty and/or pain with urination? Y N Diminished volume or flow? Y N

Do you enjoy daily activities? Y N Do you feel apathetic or complacent about previously enjoyed sports, hobbies, clubs, games, etc.? _____

Do you notice feeling more agitated/irritable than previously? _____

Do you feel less assertive in daily life than previously? _____

Would you like to discuss men's health issues specifically? _____