**Julia Strickler, ND Wellness From Within**

**CONFIDENTIAL CLIENT PROFILE**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_Height:\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle those that apply: Single Married Significant Other Do you have children? Yes No Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Live with: Spouse:\_\_\_\_ Partner:\_\_\_\_ Parents:\_\_\_\_ Children:\_\_\_\_ Friends:\_\_\_\_ Alone:\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Personal Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*……………………………………………………………………………………………………………………………………………………………………………………………*

*Please complete this two sided questionnaire as thoroughly as possible. This is a confidential record and will not be released, except when you have provided us with written authorization to do so. Thank you.*

**PRESENT HEALTH AND WELLNESS CONCERNS**

|  |  |
| --- | --- |
| Please list most important health concerns in their order of significance | Prior diagnosis of this problem? If so, what? |
| 1. |  |
| 2. |  |
| 3. |  |

What goals and/or expectations do you have for your visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any severe or life-threatening allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list prescription and over-the-counter medications that you are currently taking, with dosages (if known):

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List natural supplements, herbs, remedies including athletic performance supplements you are currently taking, with dosages:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIET**

What does your diet typically include:

Breakfast:­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beverages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFESTYLE AND PERSONAL HABITS**

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?

How do you perceive your current state of health?

Do you follow any particular diet regimens or restrictions? If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise at least 3 hours per week? Never Rarely Sometimes Regularly Competitively

 If yes, what type of exercise do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a regular spiritual, prayer, meditation, mindfulness or reflection practice?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke cigarettes/cigars or use nicotine gum? Yes No How much/often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your stress level? (1= Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

How would you rate your stress handling? (1=Poor, 10= Excellent) 1 2 3 4 5 6 7 8 9 10

In the past year, have you had one or more major stressors- for example, changed or lost your job, got separated or divorced, moved, or lost a loved one? Yes No

During the last year, stress in your life has had: ⃝ Significant impact on your health

 ⃝ Some impact on your health

 ⃝ No impact on your health

Which statement is closest to the truth regarding your support system:

 ⃝ I have lots of friends, family, or others with whom I am quite open and readily share personal information

 ⃝ I talk to friends, family, or others from time to time about personal information.

 ⃝ I rarely tell friends, family members, or anyone what is going on in my life or what I am thinking or feeling.

 ⃝ I don’t have any family or friends around with whom I can talk.

Do any of the following statements apply to you (check all that apply):

 ⃝ I feel tired and have no energy much of the time

 ⃝ I perceive myself as worthless and don’t like myself

 ⃝ I feel guilty much of the time

 ⃝ I have a hard time concentrating

 ⃝ I often feel agitated, restless, or irritable

 ⃝ I often feel hopeless and helpless

 ⃝ None of the above

Do any activities and situations give you pleasure? (examples include movies, theatre, sports, sex, being with friends or family, hobbies, etc.)

 ⃝ Yes, I enjoy many things in my life

 ⃝ Sometimes I enjoy activities in my life but other times I don’t enjoy them

 ⃝ There are many times when nothing will make me happy

 ⃝ No, I do not enjoy things in my life. I tend to withdraw and not participate in activities

 ⃝ None of the above

Do you feel depressed a lot or have you had significant depression in the past? Yes No

How much alcohol do you drink? ⃝ Don’t drink

 ⃝ Less than 1 drink per day

 ⃝ 1-2 drinks per day

 ⃝ 3 or more drinks per day

Do you eat 5-9 servings of fruits and vegetables each day? (One serving is equivalent to a medium-sized apple, pear, or orange; a small banana; or a half-cup of a vegetable like lettuce or broccoli)

 ⃝ Always

 ⃝ Usually

 ⃝ Sometimes

How often do you eat red meat, cheese, fried foods or other high fat foods? ⃝ Everyday

 ⃝ Most days

 ⃝ Some days

 ⃝ Never

Do you suffer from body aches, joint pain, or backache? Yes No *If so, is the pain:* mild moderate severe

Do you have any cravings? Yes No *If so, are your cravings for:* sweets/carbs caffeine/stimulant salt

Do you suffer from headaches or migraines? Yes No *If so, are the headaches:* mild moderate severe

Do you have any digestive issues (constipation, gas/bloating, loose stools, irritable bowel, acid reflux, etc.)? Yes No

How likely are you to consider exercising more or eating better in the near future?

 ⃝ I am not currently considering it

 ⃝ I am considering it, but don’t know how to start

 ⃝ I have thought of how to do it and am going to start soon

 ⃝ I just started in the past month

 ⃝ I have already been exercising and eating healthfully for a long time

Do you tend to overeat? Always Sometimes Never Only under times of stress

When was your last time you saw your MD? ⃝Within the last year ⃝Between 1 and 2 years ago ⃝ More than 2 years ago

When was your last routine bloodwork? ⃝Within the last year ⃝Between 1 and 2 years ago ⃝ More than 2 years ago

When was your last dental exam? ⃝Within the last year ⃝Between 1 and 2 years ago ⃝ More than 2 years ago

What is your total cholesterol? ⃝ ˂200mg/dL ⃝200mg/dL – 240mg/dL ⃝ ˃240mg/dL ⃝ ˃200mg/dL but I am on medication ⃝ Don’t know

What is your HDL cholesterol? ⃝ ˂40mg/dL ⃝ 40 – 59 mg/dL ⃝ 60mg/dL or above ⃝ Don’t know

What is your blood pressure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Don’t know

Do you know your most recent fasting blood sugar level? ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Don’t know

Do you have a close family member (parent, grandparent, sibling, or child) who has diabetes? Yes No Not sure

Have you been screened for colon cancer by colonoscopy or other diagnostic method? Yes No Not sure

Do you have a close family member (parent or sibling) who was diagnosed with colon cancer before age 60 or do you have a personal history of colon polyps or inflammatory bowel disease (Crohn’s disease or ulcerative colitis)? Yes No Not sure

Do you examine your skin for new or changing lesions on a monthly basis? Yes No Not sure how

*Female only:* Do you have a close relative (mother, sister, daughter) who has had breast cancer?

 ⃝ Yes and this relative was diagnosed after age 50

 ⃝ Yes and this relative was diagnosed before age 50

 ⃝ No

 When was your last mammogram or thermography screening? ⃝ Within the last year

 ⃝ More than 1 year ago

 ⃝ I have never had either screening

**SLEEP HABITS**

How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

 How long has this been happening? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours do you sleep each night on average? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wake up tired? Yes No How long has this been happening? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your room completely dark when you sleep at night? (no night light, street lamp, TV, etc.) Yes No

Do you get at least 30 minutes of outside daylight time, several days each week? Yes No

**OTHER**

Please include anything not covered above that you would like me to know about you and your health.