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Client Health and Lifestyle Questionnaire

Date _____

Name _____

Phone _____ Cell phone _____

Address _____

E-mail _____

Date of birth _____ Age _____ Occupation _____

Weight _____ Height _____ (BMI _____) Goal Weight _____

Why do you want to be at this weight? _____

Your weight at ages: 18 -25 years: _____ 30-35 years: _____ 40-45 years _____

50-55 years _____ 60-65 years _____ 70+ years _____

Weight changes over last 5 years: _____ Weight 1 year ago _____

Physician _____ Most recent physical examination _____

General Health: Excellent Good Fair Poor

Health Concerns: _____

Health History

Have you had or do you have any of the following health issues:

Respiratory

Asthma

Snoring

Sleep apnea

Cardiovascular

Hypertension

Heart abnormality

Heart attack

Gastrointestinal

Diarrhea

Constipation

GERD

Abdominal pain

Musculoskeletal

Aching muscles/joints

Arthritis

Back pain

Skin and Hair

Rashes/dermatitis

Skin irritations

Endocrine

High chol/triglycerides

Thyroid abnormality

Abnormal blood glucose

Diabetes

Depression

ADD/ADHD

Anxiety

Eating disorder (binge

eating/bulimia/anorexia)

Chronic headache/migraine

**List any serious illnesses or
medical conditions you have
had:**

Stress level: low, moderate, high; Stressors: _____

Tobacco use: yes or no Alcohol: drinks per week? _____

Sleep: Hours/night _____ **Any difficulties?** _____

Medications: _____

Nutritional supplements (vitamins, minerals, herbs, type and brand)

Nutrition Concerns: _____

Previous nutrition or weight management programs (what did you work on, and was it successful?)

Physical activity and/or exercise: Minutes/day _____ Days/week _____

Types of Activities (e.g., walking, yard work, dancing, swimming, biking, etc): _____

Food Allergies: _____

Typical Eating Pattern:

Morning _____

Mid Morning _____

Mid-day _____

Mid afternoon _____

Evening _____

Late Evening: _____