Naturopathic Client Questionnaire

Date: ……..... Name: ……

Address: ……..
Email……
Ph: ..……

How did you hear about CK Health? …..……..

DOB: ……..... Height: ……..cm Weight: ……..kg

Occupation: ……..

What is your primary reason for visiting a Naturopath? ……..

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Are there any other reasons? ……..

Have you ever suffered from any of these conditions? If so please give details and dates

1. Cardiovascular disease (high / low blood pressure, high cholesterol, poor circulation, angina, palpitations)
2. Liver / kidney disease
3. Digestive disorder
4. Mental or a nervous system disease
5. Reproductive disorder
6. Endocrine disorder (thyroid / diabetes)
7. Any other disease including - auto immune disease, cancer, eating disorders, STD's, glandular fever, chronic fatigue

List your childhood illnesses
List illnesses in your family history (Mother, Father, Siblings)
Do you have any known allergies or intolerances? Please give details

Do you suffer from headaches or migraines? Please give details	daily weekly monthly rarely never
Do you experience food cravings? Please give details i.e. sugar, salty foods	daily weekly monthly rarely never
Are you stressed? What is the main cause? Please give details	yes / no ☐ ☐
How regular are your bowel motions?	once daily, twice daily every second day less often than this
Do you experience diarrhoea / constipation / mucus or blood stools / indigestion / bloating? Please give details	yes / no ☐ ☐
How do you feel on waking?	
How many hours sleep do you get on average each night?	
Do you lack energy at certain times of the day? If so when?	
How often in the last year have you suffered from throat or chest infections / colds / flu? Please give details	

Do you exercise? If so how often and what are the activities?	yes / no ☐ ☐
Are you taking any medication? (including the pill) Please list all	yes / no ☐ ☐
Are you taking any supplements? Please list all	yes / no ☐ ☐

If female, do you have regular periods? Please give details	yes / no ☐ ☐
If female, how heavy is your flow?	light medium heavy
Do you use recreational drugs? If so how often?	daily weekly monthly rarely never
Do you drink alcohol? If so how often?	Daily weekly monthly rarely never
Do you smoke cigarettes? If so how many per day?	☐ yes/no ☐
Do you regularly consume caffeine, including tea, coffee, cola, energy drinks? If so, what drinks and how often?	yes/no ☐ ☐
How often do you visit the dentist?	twice yearly once year, rarely never
In recent years how much exposure have you had to nuclear imaging? (x-rays including dental, MRI, CT scans, mammograms)	
How much water do you drink each day?	

Please feel free to write any other information that you think is relevant below:

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Signature: ……..

It is helpful if you bring to your initial consultation any medications or supplements you are currently taking and any recent blood results.

I do not wish to receive regular health and lifestyle updates in the form of a newsletter ☐

Thank you for taking the time to complete this questionnaire. Please note all information given is kept confidential according to the Health Records and Information Privacy Act 2002 No 71