30 DAY CLIENT QUESTIONNAIRE

Name:	☐ M ☐ F	**Start Weight:**	**Height:**	**Goal Weight:**	
☐ Single ☐ Partnered ☐ Married	**Age:**		**Occupation:**		
Week 1 Weight:	**Week 2 Weight:**		**Week 3 Weight:**	**Final Weight:**	

HEALTH HISTORY & LIFESTYLE HABITS

Diet	Have you ever dieted: If yes, what type/how often:			☐ Yes	☐ No
	Do you experience any kinds of cravings: (sweet, salty, etc.)			☐ Yes	☐ No
	Do you cook: What percentage of food is home cooked:			☐ Yes	☐ No
	Breakfast	Lunch	Dinner	Snacks	
Beverages # of cups/cans per day?	☐ Water (in ounces)	☐ Coffee	☐ Soda	☐ Energy Drinks	☐ Juice
Alcohol	Do you drink alcohol? If so, what kind:			☐ Yes	☐ No
	How many drinks per week?				
Tobacco	Do you use tobacco? ☐ # of years ☐ Or year quit			☐ Yes	☐ No
	☐ Cigarettes – #/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
Sleep	Overall Energy Level: High ☐ Normal ☐ Low ☐ Afternoon Slump ☐ Wake feeling rested ☐ Wake feeling tired? ☐				
	Do you have trouble sleeping? ☐ Falling asleep? ☐ Waking in the night? ☐ Falling back to sleep? ☐			☐ Yes	☐ No
Elimination & Digestion	How often do you poop: 1-2/day ☐ 2-3/day ☐ Every 2-3 days ☐ Once a week ☐				
	Do you experience: bloating ☐ constipation ☐ diarrhea/loose ☐ indigestion ☐ heart burn ☐				
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Emotional	Do you ever experience: Anxiety ☐ Depression ☐ Panic Attacks ☐ Anger Management ☐				
	Overall Mood: Generally Happy ☐ Often Stressed ☐				
Do you experience headaches with any kind of regularity? If so, how often:				☐ Yes	☐ No
Do you have any joint pain? If so, where:				☐ Yes	☐ No
Do you have any skin issues: Dry ☐ Oily ☐ Rashes ☐ Eczema ☐ Psoriasis ☐ Rosacea ☐ Acne ☐ Aging ☐				☐ Yes	☐ No

WOMEN ONLY

Are you pregnant or breastfeeding?	☐ Yes	☐ No
Do you have menstrual pain, bloating, irritability, heavy flow, irregularity, or other symptoms at or around time of period?	☐ Yes	☐ No

MEN ONLY

Do you often get up to use the restroom during the night? If yes, # of times _____	☐ Yes	☐ No

ANY OTHER HEALTH CONCERNS

Ex.) Pre-diabetic, Diabetic, Cholesterol, Blood Pressure, Cholesterol, Thyroid, etc.

MEDICATIONS / SUPPLEMENTS

HEALTH GOALS

What are your main health goals?