



Optimal Health Consulting

Client Health Assessment

Date _____
 Client Name : _____
 Date of Birth: _____
 Address: _____
 City: _____ State: _____

Location : _____
 Circle One: Existing Client New Client
 Age: _____
 Zip: _____

Home Phone: _____
 Office: _____

Cell Phone: _____
 Other: _____

Best way to contact you is _____
 Email: _____

Time of day to contact _____
 Referred by : _____

Check if any of the below apply:

Heart Disease		Require corrective lenses	
High Cholesterol		Diabetes	
High blood pressure		History of Cancer	
Low blood pressure		Insulin resistance	
Rapid heart beat		Skin rashes/ Eczema	
Anxiety		Ring worm/athletes foot/other fungus	
High stress periods		Dental abscesses or problems	
Obesity		Bone loss	
Weight fluctuations		Osteoporosis	
Cold hands and/or feet		Macular Degeneration	
Hair loss (more than average)		Joint pain or stiffness, cracking	
Weight gain – inability to lose weight		Yellowing nails, peeling nails	
Trouble focusing		Bruise easily	
Low energy		Dry skin or itchy skin	
Irritable bowel		Chronic back pain	
Food allergies		Monthly Migraines	
Heartburn		Cramps/ Bloating associated	
Nausea		Trouble getting pregnant	
Headaches		Moody times, easily agitated	
Stomach bloating		Tender breasts	
Intestinal pain or gassy		Irregular periods	

Current Health Concerns & symptoms:

Are you satisfied with your sleep and the level of energy you have throughout the day? Yes or No
 If not – please explain

List prescription medicines/dosage/frequency:

Medication	Reason given by doctor	Dosage	Frequency

Describe your sleep patterns: _____

Do you nap? If so – how long? What days? _____

How many times do you eat a day?: _____

Times you typically take meals?: _____

Check all that apply to your current diet:

Eat fresh vegetables daily 3 – 4 servings	Yes	No	Drink alcohol	Yes	No
Eat fresh fruits daily 3 – 4 servings			Eat right before bedtime		
Eat processed foods			Eat dairy products		
Eat fried foods			Eat soy products		
Eat red meat			Eat wheat containing products		
Eat chicken, poultry			Eat potatoes, rice or enriched breads		
Eat fish			Dine out frequently		
Eat shell fish					
Eat sugary foods and/or crave sugar					
Drink coffee or caffeinated beverages					

Supplements currently taking and dosage if you know:

Supplement	Quantity / Dosage	Time of Day	Times per week

Describe the exercise you do regularly and the frequency:

Exercise	Length of Time	Frequency (times per week)

Share details about your known allergies (environmental, animal, and food allergies):

Allergen		Allergen	
Reaction		Reaction	

Doctors under care of:

Name: _____

Phone: _____

Name: _____

Phone: _____

