Elena KYRGOS LMFT, NTP
psychotherapist ◦ nutritional therapist

Initial Interview: Confidential Client Health Questionnaire

Consultation Date: _____ Consultation Time: _____

**** All of your personal information will remain strictly confidential! ****

Name: _____

E-mail Address: _____

Street Address: _____

City State Zip: _____

Home Phone: Work/Cell Phone: _____

Date of Birth: Place of Birth: _____

Age: Gender: Height: Current Weight: _____

Would you like your weight to be different? _____ If so, what? _____

Occupation: How many hours do you work per week? _____

Relationship Status: _____ Children? _____

Blood Type (if known): _____

Referred by: _____

Hobbies/Activities: _____

What are your health concerns? _____

What would you like to accomplish/gain from this consultation? _____

Do you sleep well? Do wake up during the night? _____

If so, what time(s)? What time do you go to bed? _____

What time do you generally wake-up? _____

P: 703-981- 0870
E: elena@elenakyrgos.com
www.elenakyrgos.com

How do you feel when you wake up? _____

Do you drink caffeinated drinks? _____ How much & how often? _____

Do you smoke? _____ How much & how often? _____

If no, why, how and when did you quit smoking? _____

Exposure to Secondhand Smoke? _____ If so, how and how long? _____

Do you drink alcohol? _____ How much & how often? _____

Do you drink soda (diet or regular)? _____ How much & how often? _____

What role does exercise play in your life? _____

Describe your weekly exercise routine (cardio/strength training/other physical activites):_____

Have you been exposed to toxic substances at work or home? _____

How much water do you drink per day? _____

Do you have any allergies? _____

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/nonprescription medications, aspirin, laxatives, diet pills, or any other supplements? Please list all below including name brands and amounts:_____

_____

_____

Do you have any known allergies to medications or herbs? Please list all: _____

_____

_____

Are you currently under a practitioner's care for a specific health issue? _____

If so, what treatments are you undergoing? _____

Please list any surgeries, accidents, injuries or childhood diseases you have had along with the type and date:_____

_____

_____

_____

What were your eating habits like as a child? (List types of foods) _____

_____

What percentage of your food is home cooked? _____

How often do you eat out? _____

What are the three worst foods you eat each week? _____

What are the three healthiest foods you eat each week? _____

Do you crave sugar? _____ Do you crave salt? _____

Do you feel tired, bloated, and/or gassy after meals? _____

Do you experience constipation or diarrhea often? _____ When & how often? _____

Do you feel excessively hungry? _____ Do you have a poor appetite? _____

What's your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Family Health History

How is your mother's health? _____

_____

How is your father's health? _____

_____

Has a **blood-related** family member of yours had any of the following health conditions? If yes, please indicate if it was their cause of death and specify their relationship to you (mother, father, sibling, maternal or paternal grandparent).

Alzheimer's	_____	Relationship to you:	_____
Asthma	_____	Relationship to you:	_____
Autoimmune disease (specify type)	_____	Relationship to you:	_____
Cancer (specify type)	_____	Relationship to you:	_____
COPD	_____	Relationship to you:	_____
Dementia	_____	Relationship to you:	_____
Diabetes (specify type)	_____	Relationship to you:	_____
Emphysema	_____	Relationship to you:	_____
Epilepsy	_____	Relationship to you:	_____
Gall bladder condition	_____	Relationship to you:	_____
Glaucoma	_____	Relationship to you:	_____
Heart attack (specify type)	_____	Relationship to you:	_____
Heart condition (specify type)	_____	Relationship to you:	_____
High blood pressure	_____	Relationship to you:	_____
Kidney disease	_____	Relationship to you:	_____
Liver disease	_____	Relationship to you:	_____
Mental illness (specify type)	_____	Relationship to you:	_____
Migraines	_____	Relationship to you:	_____
Obesity	_____	Relationship to you:	_____

Osteoarthritis _____ Relationship to you: _____

Osteoporosis _____ Relationship to you: _____

Parkinson's disease _____ Relationship to you: _____

Rheumatoid arthritis _____ Relationship to you: _____

Stroke _____ Relationship to you: _____

Thyroid condition
(specify type) _____ Relationship to you: _____

Ulcer (specify type) _____ Relationship to you: _____

Other _____ Relationship to you: _____

Other _____ Relationship to you: _____

WOMEN ONLY:

Age of your first period: _____ Are your periods regular? _____

How frequent? _____ # of pregnancies _____

How many days is your flow? _____

Do you experience PMS? _____ Is it mild or severe? _____

Are you peri-menopausal? _____ When did this change first occur? _____

Are you menopausal? _____ When was your last period? _____

List your symptoms of peri/menopause:_____

How many children have you delivered and how were they born (vaginally or by cesarean)? _____

Were there complications associated with these births? _____

Please explain: _____

Did you receive antibiotics during labor? _____

Have you ever had a miscarriage or an abortion? _____ How many? _____

MALE ONLY

Approximate age of onset of puberty: _____ # of Children: _____

Do you feel your libido is adequate? **Y N** Comments: _____

Do you wake at night to urinate? _____ How many times per night? _____

Do you have any difficulty and/or pain with urination? **Y N** Diminished volume or flow? **Y N**

Do you enjoy daily activities? **Y N**

Do you feel apathetic or complacent about previously enjoyed sports, hobbies, clubs, games, etc.? _____

_____

Do you notices feeling more agitated/irritable than previously? _____

Do you feel less assertive in daily life than previously? _____

Would you like to discuss men's health issues specifically? _____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

Have you tried addressing your current health concerns in the past? If yes, what happened? _____

_____

_____

Do you feel ready to make the changes necessary to achieve your health goals? _____

Anything else you want to share? _____

_____

_____

_____