



awakenyourhealth

clienthealthquestionnaire

Please try to answer every question, there are no 'right' or 'wrong' answers

Name: _____ Date: _____

DOB: _____ Age: _____ Email: _____

Address: _____

_____ State: _____ Postcode: _____

Mobile Number: _____ Landline: _____ (h / w?)

Are you happy to receive AYH monthly newsletter, including recipes and specials? Yes / No

Do you have any Children? Yes / No Your Occupation? _____

How did you hear about awakenyourhealth? _____

Please list the main problems you are experiencing and/or reasons for this appointment.

What do you believe the problem may be due to?

What kind of treatment(s) have you tried for the problem(s) listed above? Please detail any relevant testing or investigations and bring copies of the results to your consultation.

What three things would you most like to improve about your health over the next few weeks?

1. _____

2. _____

3. _____

What are your long term health goals?

Do you have any existing medical conditions or injuries? If so, please list:

Are you currently taking any supplements or herbal medicines? Please specify dosage brand and quantity:

Are you currently taking any medications (eg anti-inflammatories / pain relief / contraceptive pill)? Please specify dosage, brand and quantity:



Do you have any known allergies?

How would you rate your general energy levels? (energy score out of 10, please circle one)

0-2 (hard to get out of bed) 3-4 (feel sluggish but functioning) 5-7 (managing daily activities but could be better)

8-9 (generally good the majority of the time) 9+ (I feel great and am bursting with energy)

Do you feel your energy levels drop within an hour of eating?

Do you have cravings for sweets, pastries, cakes, chocolate?

How many hours of sleep would you have each night on average? (please circle)

0-4 hours 5-6 hours 7-8 hours 8+ hours

How would you rate your daily stress levels? (please circle)

low medium high

What is your current weight? _____Kg **What is your goal weight?** _____Kg

Do you suffer from any of the following symptoms regularly? (please circle)

asthma	anxiety	back pain	blood disorder
bladder problems	bloating	bronchitis	chest pain
constipation	depression	diabetes	diarrhoea
digestive problems	dizziness	epilepsy	hay fever
headaches	heart problems	high blood pressure	migraines
irritable bowel syndrome	high cholesterol	low blood pressure	palpitations
pre-menstrual-syndrome	painful period	muscle cramps	skin problems
sports injuries	sinus problems	weight gain	weight loss

Do you smoke? Yes / No (if so, how many daily?) _____

Are you an ex-smoker? Yes / No (when did you quit?) _____

What do you do for exercise? _____ **how often?** _____

What do you do for relaxation? _____ **how often?** _____



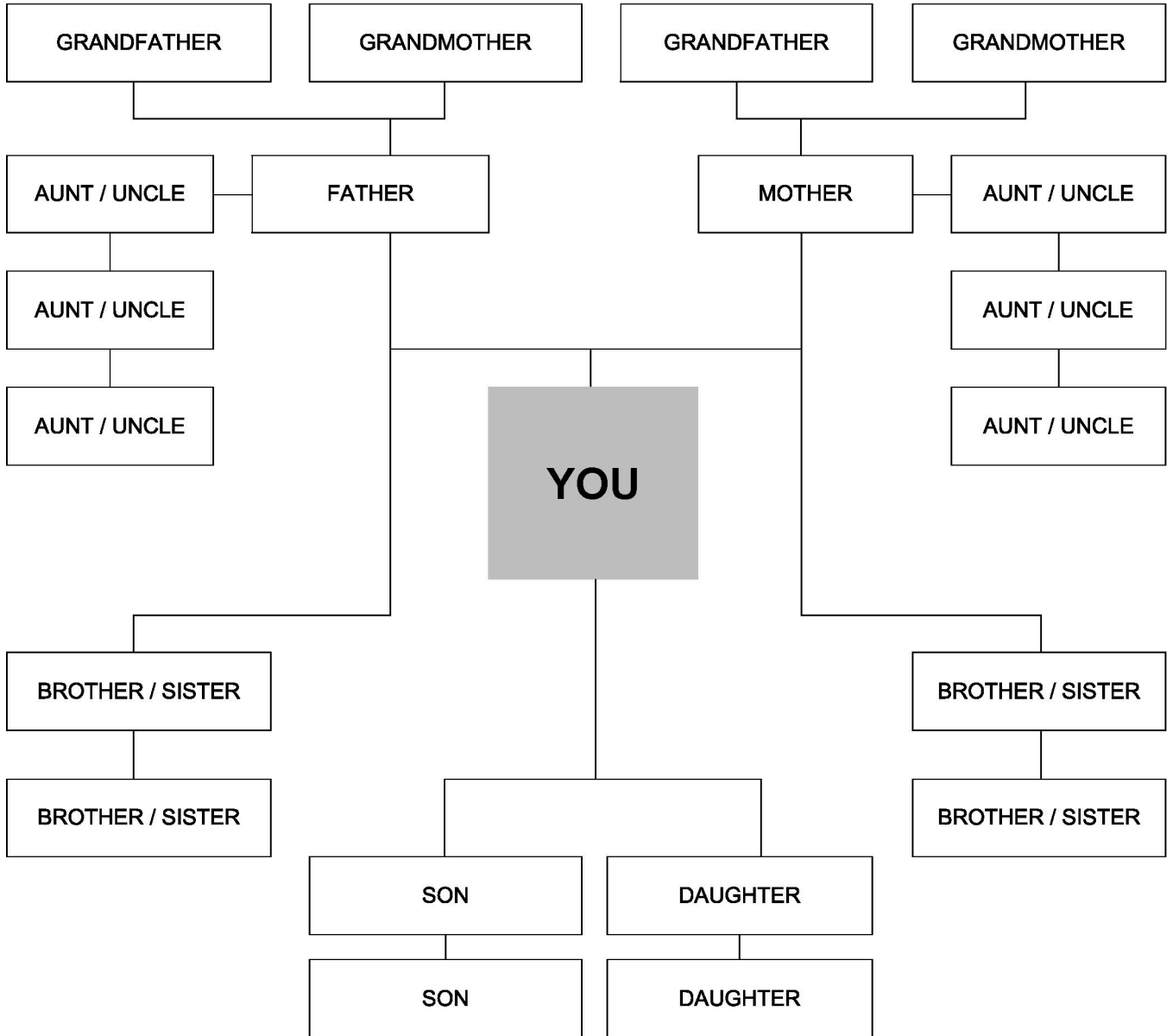
dietquestionnaire

How often do you usually eat fried foods?	Less than once a week	1 - 2 times a week	3 - 6 times a week	Every day
How many serves of bread, pasta, rice, potatoes or other starchy foods do you have a day?	0 -1 serves daily	2 serves daily	3 serves daily	4+ serves daily
How many servings of sweet foods like cakes, biscuits, lollies, chocolate do you have a day?	Usually none	1 -2 serves daily	2 - 3 serves daily	4+ serves daily
How many tea-spoons of sugar do you consume daily in hot drinks, added to foods, etc	0-3	4-6	7-9	10+
How often do you usually eat canned or fresh fish?	Rarely	1 - 2 times a week	3 - 6 times a week	Every day
How many pieces of fresh fruit do you usually eat a day?	Usually none	1 - 2 pieces a day	3 - 4 pieces a day	5+ pieces a day
How many servings of vegetables do you usually eat a day (excluding potatoes)	Usually none	1 - 2 serves a day	3 - 4 serves a day	5+ serves a day
How many cups of coffee do you usually drink a day?	Usually none	1 -2 cups daily	3 - 4 cups daily	5+ cups daily
How many cups of tea do you usually drink a day?	Usually none	1 - 2 cups daily	3 - 4 cups daily	5+ cups daily
How much soft-drink do you consume on average?	Usually none	1-2 cans a week	1 - 2 litres a week	3+ litres a week
How much water do you drink a day?	0-500ml_	500ml_ - 1 litre	1 litre - 1.5 litres	1.5+ litres



family medical health tree

Please complete the chart below indicating only chronic or significant illnesses (eg. Bowel disorders, depression, mood disorders, coeliac's disease, thyroid disease, cancer, diabetes, allergies, asthma, eczema, arthritis, heart disease, heart attack, high cholesterol and blood pressure, stroke) within the appropriate box on the family medical history tree.



Please list any additional information you feel is relevant below:

