



Woodside Wellness Questionnaire

Thank you for your interest in holistic nutrition. It is a rapidly growing brand of healthcare that is based on the principles of balancing and harmonizing the *whole* body. This is done through diet and lifestyle changes specific to you. Everyone is unique, and each plan is tailored for each individual client. A nutritionally sound way of living promotes prevention, healing and well-being, leading you down the path to optimal wellness.

All the information gathered is completely confidential and will not be shared with any third parties. Please be as candid and open as possible to get the most out of your plan.

CLIENT INFORMATION

Name: _____

Address: _____

Primary Phone #: _____

Email Address: _____

Date of Birth: _____

Profession: _____

Children? If yes, how many: _____

Marital Status: _____

Please list your main nutrition/health concerns (digestion, skin health, migraines/headaches, weight loss/gain, sports nutrition etc).

1. _____

2. _____

3. _____

List any and all diagnosis you have received for any health concern recently or in the past, as far back as childhood:	
List all your current medications. Indicate how many times you've been on antibiotics in the past 10 years:	
List all your current supplements: (vitamins, minerals, herbs)	
Family health history: List all (diabetes, cancer, high blood pressure etc)	
Mental health: Do you suffer from any anxiety or depression. If so, please provide details.	
Hours of sleep per night	
Do you wake up feeling rested?	
Do you exercise? If so, indicate what you do and how often.	

<p>Indicate your level of energy: 1 being low, 10 being high on an average day. Does your energy change throughout the day?</p>	
<p>Do you have any known allergies or suspected food intolerances. List all.</p>	
<p>List all digestive concerns you experience either now or in the past: bloating, gas, cramping, constipation, loose stools.</p>	
<p>If you were stranded on a desert island, what food would you want to eat?</p>	
<p>Do you have any cravings? If so, list all.</p>	
<p>List the top 5 foods you eat the most often.</p>	
<p>Caffeinated beverages? If so, how many per day/week? Carbonated beverages? If so, how many per day/week.</p>	<p>Any diet drinks? Y [] N []</p>
<p>Do you have any dietary restrictions? For example: no red meat, vegan, vegetarian, no milk etc. Please be specific.</p>	
<p>Are there any foods you are not willing to give up? Is there any particular food you feel addicted to?</p>	
<p>Do you consume alcohol?</p>	<p>Y [] N [] How much and how often:</p>

Do you smoke?	Y [] N [] How much and how often:
Do you do any recreational drugs?	Y [] N [] How much and how often:
How many glasses of water do you drink per day? Source?	Filtered [] Tap [] Reverse osmosis [] Bottled []
How many fruits do you eat per day? 1 serving = 1 apple	
How many vegetables do you eat per day? 1 serving = 1 cup broccoli	
Are the fruits and vegetables organic?	Y [] N [] Sometimes []
Describe your relationship with food: excellent, good, poor, food is your enemy. Be very specific.	
Emotions: Has there been any significant emotional trauma in your life? Divorce, separation, family problems, death of someone close, abuse etc	
Do you tend to eat MORE or LESS when stressed?	
Indicate your stress level from 1-10. 1 being low, 10 being very high. List the source of your stress. What is your method of coping with stress?	
Are <i>all</i> your relationships healthy & fulfilling?	
Do you ever eat for emotional reasons?	
Do you have or have you ever had an eating disorder? Either under-eating or over-eating. Please explain.	

WOMEN ONLY Do you experience any symptoms of PMS? Cramping, bloating, headaches, change in mood, breast tenderness	
Do you experience emotional upset at the same time each month? If so, be specific – depression, anxiety, nervousness, excitability, extreme emotions.	
How often do you have a menstrual cycle?	
Are you on the birth control or any form of hormone replacement synthetic or natural? How many months/years?	
Do you have a healthy sex drive? If not, when was the last time you can remember having one?	

Nutritional Expectations

1. What do expect from your nutrition program?
2. How do you think your nutrition program will affect your daily life?
3. Have you tried any nutrition programs or diets in the past to reach your goals and were you successful?
4. How would you rate your nutrition on in these areas: poor, needs improvement, good or excellent:

Scheduling/planning: _____

Balancing carbs, fat, protein ratios: _____

Level of commitment to a program: _____

Please include anything else you want to cover off in your nutrition session:

Thank you for taking the time to complete this questionnaire. I look forward to helping you achieve your best health ever!

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7 DAY FOOD JOURNAL

Day	Breakfast	Lunch	Dinner	Snacks & Liquid Comments
1	Time:	Time:	Time:	
2	Time:	Time:	Time:	
3	Time:	Time:	Time:	
4	Time:	Time:	Time:	
5	Time:	Time:	Time:	
6	Time:	Time:	Time:	
7	Time:	Time:	Time:	

Make a note of any foods that cause a reaction: bloated, tired, headache, constipation under comments.