Nourishing You

Nourished + Free Discovery Call Questionnaire

Thank you for taking the time to fill out this form and provide us with details of your health, goals and medical history. I know this form is long; however, the more information you are able to fill out the better our discovery call will go and the less time we need to spend on your health history and instead dive in and focus on what you are looking to heal. The form should not take you more than 20 minutes max to fill out. If something does not apply to you then you do not have to answer it. If you aren't sure about an answer just put down what you think you know and move on to the next question. Please have this formed completed, dated, and signed at least 48 hours prior to our call unless I have told you otherwise. I look forward to connecting with you and am honored to get to spend the time getting to know you! With love and belief - Carrie

Client Information

First name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Occupation

Hours per week

Referred by

Person Information

Age

Height (in inches)

Current Weight

Family/Living Situation

Children

Pets

Family History

Family Illnesses

Family Member	Illness

Personal Health History

Medical Diagnosis

Diagnosis	Current	Past	Date of Onset
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Please list the date and description of any hospitalizations/surgical procedures you have had (including breast reduction or augmentation).

Hospitalization/Surgery	Date	Reason

How do your health problems interfere with your life?

Please be as specific as possible.

What are you currently doing to treat these concerns/symptoms? And have you experienced any success with these approaches?

Please be as specific as possible.

List any medicine you are currently taking.

Medicine Name	Dosage	Frequency / Route	Start Date	Comments

List all vitamins, minerals, herbs and nutritional supplements you are now taking.

Name	Dosage	Frequency / Route	Start Date	Comments

How often did you take antibiotics in infancy/childhood?

How often did you take antibiotics as a teen?

How often have you taken antibiotics as an adult?

What other health practitioners/healers/coaches are you currently working with?

Name of Practitioner/Healer/Coach	Speciality/Profession	Date You Started Seeing Them

Do you have any allergies? (cat, dog, dust, pollen, medicine, food, etc.) ◯ Yes ◯ No

If you answered yes to the above allergy question please specify as to the type of allergies you have and your reaction (cat, dog, dust, pollen, medicine, food, etc.)

Food/Environmental/Medical/Etc.	Reaction

Personal Health Continued

Bowel Movement Frequency

- ☐ 1–3 times per day
- ☐ more than 3 times per day
- ☐ not regularly every day

Bowel Movement Consistency

- ☐ soft & well formed
- ☐ often float
- ☐ difficult to pass
- ☐ diarrhea
- ☐ thin, long or narrow
- ☐ small and hard
- ☐ loose but not watery
- ☐ alternating between hard and loose

Do you experience digestive difficulties? (ie. bloating, gas, constipation..etc)

Do you strain to have bowel movements? ○ Yes ○ No

Do you take laxatives at least once a week? ○ Yes ○ No

Gastrointestinal

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Past	Now
Irritable Bowel Syndrome		☐	☐
Crohn's		☐	☐
Ulcertative Colitis		☐	☐
Gastritis or Peptic Ulcer Disease		☐	☐
GERD (reflux or heartburn)		☐	☐

Celiac Disease		☐	☐
SIBO		☐	☐
Gut infections		☐	☐
Dysbiosis		☐	☐
Leaky gut		☐	☐
Food allergies, intolerances or reactions		☐	☐
Gallstones		☐	☐
Known absorption or assimilation issues		☐	☐
Other		☐	☐

Cardiovascular

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Past	Now
Heart attack		☐	☐
Heart Disease		☐	☐
Stroke		☐	☐
Elevated cholesterol		☐	☐
Arrhythmia (irregular heartbeat		☐	☐
Hypertension (high blood pressure)		☐	☐
Rheumatic Fever		☐	☐
Mitral Valve Prolapse		☐	☐
Other		☐	☐

Hormones/Metabolic

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Past	Now
Type 1 Diabetes		☐	☐
Type 2 Diabetes		☐	☐
Type 2 Diabetes		☐	☐
Metabolic Syndrome		☐	☐

Insulin Resistance or Pre-Diabetes		☐	☐
Hypothyroidism (low thyroid)		☐	☐
Hyperthyroidism (overactive thyroid)		☐	☐
Hashimoto's (autoimmune hypothyroid)		☐	☐
Grave's Disease (autoimmune hyperthyroid)		☐	☐
Endocrine problems		☐	☐
Polycystic Ovarian Syndrome (PCOS)		☐	☐
Infertility		☐	☐
Weight gain		☐	☐
Weight loss		☐	☐
Frequent weight fluctuations		☐	☐
Eating disorder		☐	☐
Menopause difficulties		☐	☐
Hair loss		☐	☐
Other		☐	☐

Cancer

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Past	Now
Lung Cancer		☐	☐
Breast Cancer		☐	☐
Colon Cancer		☐	☐
Ovarian Cancer		☐	☐
Prostate Cancer		☐	☐
Skin Cancer (Melanoma)		☐	☐
Skin Cancer (Squamous, Basal)		☐	☐
Other		☐	☐

Genital & Urinary Systems

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Past	Now
Kidney Stones		☐	☐
Gout		☐	☐
Erectile Dysfunction or Sexual Dysfunction		☐	☐
Interstitial Cystitis		☐	☐
Frequent urinary tract infections		☐	☐
Frequent Yeast Infections		☐	☐
Other		☐	☐

Musculoskeletal/Pain

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Past	Now
Osteoarthritis		☐	☐
Fibromyalgia		☐	☐
Chronic Pain		☐	☐
Sore muscles or joints, undiagnosed		☐	☐
Other		☐	☐

Immune/Inflammatory

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Past	Now
Chronic Fatigue Syndrome		☐	☐
Rheumatoid Arthritis		☐	☐
Lupus SLE		☐	☐
Raynaud's		☐	☐
Psoriasis		☐	☐

Mixed Connetive Tissue Disease (MCTD)		☐	☐
Poor immune function (frequent infections)		☐	☐
Food allergies		☐	☐
Environmental allergies		☐	☐
Multiple chemical sensitivities		☐	☐
Latex allergy		☐	☐
Hepatitis		☐	☐
Lyme (and co-infections)		☐	☐
Chronic Infections (Epstein-Barr, Cytomegalo-virus, Herpes, etc.)		☐	☐
Other		☐	☐

Respiratory Conditions

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Past	Now
Asthma		☐	☐
Chronic Sinusitis		☐	☐
Bronchitis		☐	☐
Emphysema		☐	☐
Pneumonia		☐	☐
Sleep Apnea		☐	☐
Frequent or recurrent Colds/Flus		☐	☐
Other		☐	☐

Skin Conditions

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Past	Now
Eczema		☐	☐
Psoriasis		☐	☐

Dermatitis		☐	☐
Hives		☐	☐
Rash, undiagnosed		☐	☐
Acne		☐	☐
Skin Cancer (Melanoma)		☐	☐
Skin Cancer (Squamous, Basal)		☐	☐
Other		☐	☐

Neurologic/Mood

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Past	Now
Depression		☐	☐
Anxiety		☐	☐
Bipolar Disorder		☐	☐
Schizophrenia		☐	☐
Headaches		☐	☐
Migraines		☐	☐
ADD/ADHD		☐	☐
Autism		☐	☐
Mild Cognitive Impairment		☐	☐
Memory problems		☐	☐
Memory problems		☐	☐
Multiple Sclerosis		☐	☐
ALS		☐	☐
Seizures		☐	☐
Alzheimer's		☐	☐
Other		☐	☐

How is your mood in general? Do you experience more anxiety, depression, or anger than you would like?

Please be as specific as possible.

On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

1 = Worst, 10 = Best

At what point in your life did you feel best? And why?

Give as much detail as possible.

Please provide any other information that may be relevant but hasn't been covered in regard to your mood/mental health/emotional health.

Give as much detail as possible.

Miscellaneous

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Past	Now
Anemia		☐	☐
Chicken Pox		☐	☐
German Measles		☐	☐
Measles		☐	☐
Mononucleosis		☐	☐
Mumps		☐	☐
Sleep Apnea		☐	☐
Whooping Cough		☐	☐

Tuberculosis		☐	☐
Known genetic variants (SNPs, polymorphisms, etc)		☐	☐
Other		☐	☐

Please check frequency of the following:

	Yes	No	Sometimes
Short term memory impairment	☐	☐	☐
Shortened focus of attention and ability to concentrate	☐	☐	☐
Coordination and balance problems	☐	☐	☐
Problems with lack of inhibition	☐	☐	☐
Poor organization abilities	☐	☐	☐
Problems with time management (late or forget appts)	☐	☐	☐
Mood instability	☐	☐	☐
Difficulty understanding speech and word finding	☐	☐	☐
Brain fog, brain fatigue	☐	☐	☐
Lower effectiveness at work, home or school	☐	☐	☐
Judgment problems like leaving the stove on, etc	☐	☐	☐

Relationship with Food

Any testing for Celiac Disease? ◯ Yes ◯ No

Do you have a history of diagnosed or suspected Eating Disorders (Bulimia, Binge Eating Disorder, Anorexia Nervosa, Orthorexia...etc.)? ◯ Yes ◯ No

Do you have a history of suspected addictions (Food, drug, alcohol, behavioral, etc.)? ◯ Yes ◯ No

Are there any foods that you avoid because of the way they make you feel? ◯ Yes ◯ No

Do you have symptoms immediately after eating (any food at all|) like bloating, gas, sneezing, or hives? ◯ Yes ◯ No

If you answered yes to the above question on foods that you avoid please fill out the chart below with the types of foods you avoid and the symptoms you experience from eating that particular food(s).

Name of the Food	Symptom(s)

Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, joint pain, brain fog, etc.? ◯ Yes ◯ No

Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, joint pain, brain fog, etc.? ◯ Yes ◯ No

Besides for food allergies, religious reasons or food sensitivities do you avoid certain foods? ◯ Yes ◯ No

If you answered yes to the above question please fill in the table below with the foods you avoid and why.

Food Avoided	Reason for Avoiding Them

Are you currently on a special diet?

- ☐ Autoimmune paleo (AIP)
- ☐ SCD/GAPS
- ☐ dairy restricted or dairy-free
- ☐ vegetarian
- ☐ vegan
- ☐ other (please describe below)
- ☐ paleo
- ☐ blood type
- ☐ raw
- ☐ refined sugar-free
- ☐ gluten-free

If you checked any of the above diets please state why you are on this diet and approximately for how long you have been on it.

If you checked the "Other" box from the special diet question above, please describe in more detail here.

What foods (if any) do you crave?

Please be as specific as possible.

What percentage of your meals are home cooked?

How often do you eat out per week?

How much water do you drink daily?

Do you consume coffee daily? ○ Yes ○ No

Do you consume tea daily? ○ Yes ○ No

Do you consume alcohol daily? ○ Yes ○ No

Do you tend to skip meals? ○ Yes ○ No

Do you engage in any of the following food behaviors:

Food Behavior	Past	Present	Sometimes	Never	Other/Comments
Binge Eating	☐	☐	☐	☐	
Overeating	☐	☐	☐	☐	
Calorie Restriction	☐	☐	☐	☐	
Tracking Macros	☐	☐	☐	☐	
Weighing Your Food	☐	☐	☐	☐	
Fasting	☐	☐	☐	☐	
Cleanses	☐	☐	☐	☐	
Emotional Eating	☐	☐	☐	☐	
Comfort Eating	☐	☐	☐	☐	
Eating because you believe you are addicted to food	☐	☐	☐	☐	
Using exercise as a reward to eat food	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

If you checked "Other" in the above chart please explain below.

Please Check All that Apply

	Yes	No	Sometimes	Comments
All I think about is food and my body.	☐	☐	☐	
I've tried multiple diets to try and lose weight but can never stick to the diet for a long period of time.	☐	☐	☐	
I do not trust myself around certain foods.	☐	☐	☐	
I tend to eat when feelings of discomfort arise such as boredom, loneliness, depression, anger and anxiety to soothe my emotions.	☐	☐	☐	
I feel out of control with food.	☐	☐	☐	
I believe I do not have the willpower when it comes to dieting and/or eating certain foods.	☐	☐	☐	
I am always dieting and/or following some type of food and meal plan.	☐	☐	☐	
I weigh myself daily.	☐	☐	☐	
I am constantly dissatisfied with my body.	☐	☐	☐	
I am always comparing my body to other women's bodies.	☐	☐	☐	
I am always picking my body apart.	☐	☐	☐	
I use the mirror to body check.	☐	☐	☐	

If I am not feeling good about my body I will stay home and miss out on social engagements.	☐	☐	☐	
I use exercise to change my body's appearance.	☐	☐	☐	
I use exercise as a way to earn my food.	☐	☐	☐	
I use exercise to compensate for what I have eaten.	☐	☐	☐	
I have difficulty sticking to an exercise regimen.	☐	☐	☐	
Other	☐	☐	☐	

If you checked "Other" above please explain below.

Please describe your relationship with food.

Please be as specific as possible. The more detail the better.

Is there anything else I should know about your current diet, food and body history, and/or relationship to food?

Please be as specific as possible. The more detail the better.

Lifestyle History

Cigarettes/Alcohol/Drugs

Have you abused drugs, prescription medicine, alcohol, tobacco and/or caffeine? Are you still?
Please give provide as much information as possible that you are comfortable sharing.

How many cigarettes do you smoke per day?

For how many years? If you quit, how long ago?

Stress

On a scale from 1 (not stressed) to 10 (super stressed) rate your average daily stress level.

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

List your main stressors.

How do you handle stress? And are your methods effective?
Please explain.

Sleep

Approximately how many hours do you sleep a night?

Do you stay awake all day without dozing/napping?

Do you wake feeling rested?

Do you have trouble falling asleep? Staying asleep?

Do you wake frequently during the night? ◯ Yes ◯ No

Exercise

How often do you exercise each week? And for how long?

What types of exercise do you engage in?

What is your primary motivation (reason) for exercising?

Do you have fun exercising?

Describe your relationship with exercise.

Fun + Creativity

What do you do for fun? What are your hobbies?

How do you express your creativity?

For Women Only

Do you get your period each month? ◯ Yes ◯ No

Are you in Perimenopause? ◯ Yes ◯ No

Are you in Postmenopause? ◯ Yes ◯ No

In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

Have you experienced any yeast infections or urinary tract infections? Are they regular?

Have you/do you still take birth control pills: If so, please list length of time and type

Have you had any problems with conception or pregnancy?

Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

Please provide any other information that you feel may be relevant.

Support + Goals

Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no

Who will be most supportive of you making these lifestyle changes? And can you commit to telling them the new lifestyle changes you will be making?

What is your level of commitment to improving your overall health? 1 = not committed and 10 = I am ready to start NOW!

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

What are your health concerns/goals? What are the number 1-2 things you are looking to change in order to improve your overall health and life?

Please provide as much detail as possible.

Why do you want to achieve this for yourself? How will this impact your life for the better and the lives of those who you care about most?

What obstacles/challenges may get in the way of your goals?

Please describe any other information you think would be useful in helping to address your health concern(s) / goal(s):

Date

Client

X

Print name: **Date:**