SimpleGoodHealth.com

NEW CLIENT QUESTIONAIRE

I am dedicated to helping you achieve optimal health and well-being. Please answer all questions to the best of your ability and return these forms to me by email, or regular mail. Please include any lab tests you have had done in the past 1-2 years. If you need more space, please use another piece of paper. Please let me know if you have any questions about these forms. I look forward to working with you.

Today's Date:

Name:

Address:

Phone Numbers: Cell:

Work: Home:

What phone number would you like Micki Contini to call you on if you are a virtual client?

Skype name (If you would like to use Skype):

Email:

Can we add you our mailing list for health updates?

Who referred you/How did you hear about us?

Occupation:

Gender: Age: Date of Birth:

Height: Weight:

Marital Status: Number of Children:

Social Security #:

Allergies:

Do you take prescription drugs, including birth control pills (please list)? If taking birth control pills, is it for health reasons or contraception?

Do you have any history of physical trauma or surgeries (list surgeries)?

Have you ever had your tonsils, appendix, or gall bladder removed?

Describe a brief history of your dental health including mercury-containing amalgams/fillings, infections, root canals etc.:

Do you smoke?

Have you ever smoked?

What is your current stress level on a scale of 1-10 (1 is low stress):

List pets:

Do you currently or have you ever lived with someone who smoked, even as a child?

Please list any natural supplements your are currently taking:

Tell me about your chief complaint(s)

What is your opinion of what has happened to your health?

Can you think of any predisposing factors such as genetic or environmental issues that could be related to your illness?

Can you think of anything that triggered your condition/symptoms?

Do you know what is perpetuating/contributing to your condition?

How many hours do you sleep at night?

Do you have trouble falling asleep?

Do you wake up in the middle of the night?

Tell me about your exercise habits now and in the past?

Now:

Past:

Do you follow a specific diet or nutrition plan such as vegan, vegetarian, paleo etc.?

Do you think that stress is part of your condition?

Are there any stressful or “toxic” relationships in your life that could be wearing you down?

Do you experience anxiety, depression or other mood imbalances (anger, grief, sadness)?

Do you have issues with brain fog, short or long-term memory?

If you suffer from fatigue, does your day have a particular pattern of when energy is highest and lowest?

highest:

lowest:

Do you get sick easily such as colds or the flu?

What is your family history of disease such as heart disease, cancer, diabetes etc.?

Are there any treatments, medications, supplements etc. that have helped you with your health?

Have you ever had exposure to environmental, industrial or toxic compounds?

Please list your history of infections:

Have you ever used prescription drugs at any time in the past, i.e., antibiotics during childhood?

Have you ever been bitten by a tick and if so, was there a rash?

Have you ever lived somewhere that contained mold?

Do you have any history of miscarriages or abortion?

Do you consume alcoholic beverages? If so, how much? What was your frequency of alcoholic beverage intake at any time in the past?

Do you consider yourself overweight, underweight, or ideal weight?

Do you live in a urban or rural area?

Is your water source city or well and is it purified?

Who do you live with?

Tell me about your job:

- Do you like it?
- Do you work second or third shift?

Tell me about all your previous jobs?

Tell me about your hobbies?

Do you have problems with constipation or diarrhea?

How often per day do you have bowel movements?

If a digestive problem exists, how long has it persisted?

Do you have any problems with urination relating to frequency or pain? If so, how long?

Do you have ongoing pain in any part of your body? If so, how long?

Have you used recreational drugs at any time in the past? If so, what was used, how long was it used, and what was the frequency?

Do you currently use recreational drugs?

Have you ever traveled to foreign countries, including Mexico? If so, did you ever suffer from “Montezuma’s revenge” or any other GI disturbances?

What was the health of your mother during your pregnancy?

Did either of your parents smoke or ingest significant amounts of alcohol before, during, or after the pregnancy?

Do you know if the delivery was difficult?

Were you delivered via vaginal birth or Caesarian section?

What was your overall health status during your first five years of age?

List any childhood illnesses:

What was your family life like during your first five years of age?

Were you a happy child during the first five years of age?

Did you ever have any type of eating disorder such as bingeing or purging?

How fast do you eat?

Do you chew your food thoroughly?

What do you think about when you eat?

Do you ever eat standing or “on the run?”

Do you feel like you have meaning and purpose in your life?

Is there anything else I should know about you that we have not yet discussed?

How did you feel about answering these questions?

GLUTEN QUESTIONNAIRE

Gluten intolerance has been found to be most common among people of Irish, English, Scottish, Scandinavian, and Eastern European. Often times it is assumed that gluten intolerance is a food allergy, but it is not. It is actually an autoimmune process, which affects an alarming percentage of the population. The most significant symptoms are weight gain, fatigue and depression. The following test ican be used to help you to understand the symptoms and signs that are likely to go along with gluten intolerance.

Test Interpretation Guide Please combine both sections.

Number of "Yes" Responses		Potential for Gluten Intolerance
4 or less	=	Not likely
5 – 8	=	Suspected
9 or more	=	Very likely

Do any of the following apply to you?

Yes	No	Weight gain
Yes	No	Unexplained fatigue
Yes	No	Difficulty relaxing, feel tense frequently
Yes	No	Unexplained digestive problems
Yes	No	Female hormone imbalances, (PMS, menopausal symptoms)
Yes	No	Muscle or joint pain or stiffness of unknown cause
Yes	No	Migraine like headaches
Yes	No	Food allergies/sensitivities
Yes	No	Difficulty digesting dairy products
Yes	No	Tendency to over consume alcohol
Yes	No	Overly sensitive to physical and emotional pain, cry easily
Yes	No	Cravings for sweets, bread, carbohydrates
Yes	No	Tendency to overeat sweets, bread, carbohydrates
Yes	No	Abdominal pain or cramping
Yes	No	Abdominal bloating or distention
Yes	No	Intestinal gas
Yes	No	"Love" specific foods
Yes	No	Eat when upset, eat to relax
Yes	No	Constipation or diarrhea of no known cause
Yes	No	Unexplained skin problems/rashes
Yes	No	Difficulty gaining weight

Have you suffered from any of the following conditions?

Yes	No	Allergies
Yes	No	Depression
Yes	No	Anorexia
Yes	No	Bulimia
Yes	No	Rosacea
Yes	No	Diabetes
Yes	No	Osteoporosis/bone loss
Yes	No	Iron deficiency/anemia
Yes	No	Chronic fatigue
Yes	No	Irritable bowel syndrome
Yes	No	Crohn's disease
Yes	No	Ulcerative colitis
Yes	No	Candida
Yes	No	Hypoglycemia
Yes	No	Lactose intolerance
Yes	No	Alcoholism

TOTAL

Important Practice Information

Cancellation Policy:

I have a 24-hour cancellation policy. You must contact me within 24 hours to cancel or reschedule your appointment or you will be charged for that appointment. I understand that there are unpredictable occurrences in life that cannot be helped so please contact me to explain your unique situation and the fee may be waived. If you are going to be more than 15 minutes late to your appointment, call me to reschedule. I do our best to respect every client's appointment and time.

Email Policy:

I will do our best to answer your question in a timely manner. You will get a response asap.

Supplement Policy:

I spend a great deal of time researching the highest quality and most effective supplements available. If you ever have a bad reaction to a supplement that I recommend you can always bring it back for a full refund or exchange it for another supplement that your body can tolerate better. Supplements that are greater than 6 months old cannot be returned. This policy only applies to supplements purchased from the office and not from supplements drop-shipped directly from the manufacturer.

Cell Phone Policy:

Please turn off your cell phone during your appointment time.

Credentials:

Micki Contini, MS CNC is a certified holistic nutrition consultant. Micki Contini is not a Medical Doctor. Micki Contini does not treat disease but rather is focused on supporting the bodies natural healing processes by focusing on finding the underlying causes of health problems and helping clients get well through nutrition, lifestyle, supplementation and herbal supplements when necessary.

My goal is to help you get well by any means necessary. If I cannot help you, I will find someone who can. I am honored that you have chosen me to help you with your health concerns and I look forward to serving you.

I understand all of the above policies and procedures

Signature (Electronic or Hand-written):_____