



# Client Assessment Questionnaire

LifeArts – Howard Chiropractic, PC

## DEMOGRAPHIC DATA

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home telephone: \_\_\_\_\_  
 \_\_\_\_\_ Cell telephone: \_\_\_\_\_  
 \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Sex: M F Age \_\_\_\_\_ Birth date \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## HEALTH HISTORY

1. What medical concerns (e.g., pregnancy), if any, do you have at present time?

2. Do any of your blood relatives have any of the following problems?

Cancer	<input type="checkbox"/> yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> yes <input type="checkbox"/> No
Heart disease	<input type="checkbox"/> yes <input type="checkbox"/> No	Thyroid disorder	<input type="checkbox"/> yes <input type="checkbox"/> No
High cholesterol	<input type="checkbox"/> yes <input type="checkbox"/> No	Obesity	<input type="checkbox"/> yes <input type="checkbox"/> No
Other metabolic disorder	<input type="checkbox"/> yes <input type="checkbox"/> No	Explain:	

3. Do you have complaints about any of the following?

<input type="checkbox"/> Appetite	<input type="checkbox"/> Constipation	<input type="checkbox"/> Menstrual difficulties
<input type="checkbox"/> Bruising	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Sudden weight change
<input type="checkbox"/> Chewing/swallowing	<input type="checkbox"/> Edema (swelling)	<input type="checkbox"/> Stress
	<input type="checkbox"/> Indigestion	

4. Do you use tobacco in any way?  yes  no How much? \_\_\_\_\_  
 Did you recently stop smoking?  yes  no Method: smoking / chewing

5. Do you drink alcohol?  yes  no How much? \_\_\_\_\_

6. Do you enjoy physical activity?  yes  no Explain: \_\_\_\_\_

7. List any food allergies or intolerances:  
\_\_\_\_\_  
\_\_\_\_\_

## DRUG HISTORY

List any prescribed, over-the-counter, herbal, or vitamin/mineral supplements you take.  
\_\_\_\_\_  
\_\_\_\_\_

## DIET HISTORY

1. Do you follow a special dietary plan, such as low cholesterol, kosher, or vegetarian?

2. Have you ever followed a special diet? \_\_\_\_\_ Explain: \_\_\_\_\_

3. Are there certain foods that you do not eat? \_\_\_\_\_

4. Do you eat at regular times each day?  yes  no How often?

**DIET HISTORY (cont'd)**

5. Identify any foods you particularly like: \_\_\_\_\_
6. What change would you like to make?  
 Improve my eating habits                       Improve my activity level  
 Learn to manage my weight                       Improve my cholesterol/triglyceride levels  
 Other \_\_\_\_\_
7. Please add any additional information you feel may help me understand your nutritional health: \_\_\_\_\_
8. It would be helpful to know your expectations. Please check one of the following to indicate the amount of structure you want.  
 I want a lot of structure but freedom to select foods. I want to use the exchange system. Example: 1 milk, 2 starch, 1 fruit, and 1 fat exchange  
 I want some structure and freedom to select foods. I want to use a food group plan. Example: 1 serving of dairy foods, fruits, and fat and oil group; 2 servings of grain  
 I don't want a diet. I just want to eat better. I will just set food goals each week.

**SOCIOECONOMIC HISTORY**

1. Circle the last year of school attended:  
 1 2 3 4 5 6 7 8                      9 10 11 12                      1 2 3 4                      M.A.                      Ph.D.  
 Grade School                      High School                      College
- Other type of school: \_\_\_\_\_
2. Are you employed? \_\_\_\_\_ Occupation \_\_\_\_\_
3. How many people in your household? \_\_\_\_\_ Ages? \_\_\_\_\_
4. Present marital status (circle one):  
 Single                      Married                      Divorced                      Widowed                      Separated                      Engaged
5. Who prepares most of the meals in your home? \_\_\_\_\_ Shopping? \_\_\_\_\_
6. Do you use convenience or fast food daily?     yes     no
7. How often do you eat out? \_\_\_\_\_ Where? \_\_\_\_\_
8. Have you made any food changes in your life you feel good about?     yes     no
9. Who could support and encourage you to make these changes? \_\_\_\_\_

**EDUCATION INTERESTS**

- What information would you like from our counselor?
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Weight management        | <input type="checkbox"/> Eating out      | <input type="checkbox"/> Exercise         |
| <input type="checkbox"/> Healthy food preparation | <input type="checkbox"/> Portion size    | <input type="checkbox"/> Alcohol calories |
| <input type="checkbox"/> Fiber                    | <input type="checkbox"/> Eating less fat | <input type="checkbox"/> Meal planning    |
| <input type="checkbox"/> Food labels              | <input type="checkbox"/> Walking program | <input type="checkbox"/> Snack foods      |
| <input type="checkbox"/> Other                    |  |   |