clear rivers
HOLISTICS

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Please write or print clearly, and return it 48 hours before our appointment.

Email: kori@clearrivers holistics.com Phone: 970.275.2789

Name

Mailing Address

Email Address

Current Address

How often do you check email?

Age Height

Home Phone

Cell Phone

Date and Place of Birth

Current Weight ____________________

Weight Six Months Ago ____________________

One Year Ago ____________________

Would you like your weight to be different?

YES NO

If so, how?

Relationship Status ____________________

Children? YES NO

Pets? YES NO

Occupation ____________________

Hours of Work Per Week ____________________

What is Your Ancestry? ____________________

Blood Type (if known) ____________________

Referred By ____________________

Please list your main health concerns: ______

Any other concerns and/or goals? ______

At what point in your life did you feel best? ______

The most important thing I should do to improve my health is : ______

Do you sleep well? YES NO

How many hours? ______

Time to bed ______ Time wake up ______

Do you wake up at night? YES NO

If so, why? ______

At what time? ______

How do you feel when you wake up?

______

On a scale from 1-10, how much stress do you have in your life right now? ______

How is your energy level throughout the day?

______

Do you tend to get sleepy at any point or is your energy steady throughout the day? ______

Do you have any digestive issues? Please explain :

______

Do you experience discomfort (pain, gas, bloating, heartburn) after eating? YES NO

Please explain :

______

Number of bowel movements per day: ______

Do you ever experience constipation or diarrhea?

If yes, please explain :

______

Any known food allergies or sensitivities?

Please list :

______

FOR WOMEN ONLY

Age of your first period : ____________ Are your periods regular? YES NO

How many days in your flow? ____________ How frequent? ____________

Do you experience PMS? YES NO If yes, please describe symptoms :

Birth control history: ____________

Yeast infections or UTI's? YES NO

MEDICAL HISTORY & CURRENT CARE

Please list any surgeries, accidents, injuries, hospitalizations, or childhood diseases you have had along with the type and the date:

Are you currently under a practitioner's care for a specific health issue? YES NO

If so, what treatments are you receiving? ____________

Any healers, helpers, or therapies with which you are involved? Please list:

Please list any vitamins/minerals/herbs/homeopathic remedies, prescription/non-prescription medications, diet pills, or any other supplements?

Please list any known allergies to medications or herbs: ____________

What foods did you eat often as a child?

BREAKFAST	LUNCH	DINNER	SNACKS	LIQUIDS

What's your food like these days?

BREAKFAST	LUNCH	DINNER	SNACKS	LIQUIDS

What percentage of your food is home cooked? ____________ Do you cook? YES NO

Where do you get the rest from? ____________

How much water do you drink per day? ____________ Do you drink caffeinated drinks? YES NO

Which ones, how much, and how often? ____________

Do you drink alcoholic drinks? YES NO

Which ones, how much, and how often? ____________

Do you drink soda? YES NO Diet or Regular (check one)

Which ones, how much, and how often? ____________

Do you crave sugar, salt, coffee, cigarettes, alcohol, or have any major addictions? YES NO
If yes, please explain :

____

____

Do you smoke? YES NO How much and how often? ____________

If you used to smoke but quit – why, how and when did you quit smoking?

____

What role do sports and exercise play in your life? ____________

Please list any hobbies or activities : ____________

FAMILY HEALTH HISTORY

How is your mother's health?

How is your father's health?

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? YES NO

Have you tried addressing your current health concerns in the past? YES NO
If yes, please explain :

Do you feel ready to make the changes necessary to achieve your health goals? YES NO

Anything else you want to share?

DISCLAIMERS

The Client understands that the role of the Health Coach is not to prescribe or assess micro- and macronutrient levels; provide health care, medical or nutrition therapy services; or to diagnose, treat or cure any disease, condition or other physical or mental ailment of the human body. Rather, the Coach is a mentor and guide who has been trained in holistic health coaching to help clients reach their own health goals by helping clients devise and implement positive, sustainable lifestyle changes. The Client understands that the Coach is not acting in the capacity of a doctor, licensed dietician-nutritionist, psychologist or other licensed or registered professional, and that any advice given by the Coach is not meant to take the place of advice by these professionals. If the Client is under the care of a health care professional or currently uses prescription medications, the Client should discuss any dietary changes or potential dietary supplements use with his or her doctor, and should not discontinue any prescription medications without first consulting his or her doctor.

The Client has chosen to work with the Coach and understands that the information received should not be seen as medical or nursing advice and is not meant to take the place of seeing licensed health professionals.

PERSONAL RESPONSIBILITY AND RELEASE OF HEALTH CARE RELATED CLAIMS

The Client acknowledges that the Client takes full responsibility for the Client's life and well-being, as well as the lives and well-being of the Client's family and children (where applicable), and all decisions made during and after this program.

The Client expressly assumes the risks of the Program, including the risks of trying new foods or supplements, and the risks inherent in making lifestyle changes. The Client releases the Coach from any and all liability, damages, causes of action, allegations, suits, sums of money, claims and demands whatsoever, in law or equity, which the Client ever had, now has or will have in the future against the Coach, arising from the Client's past or future participation in, or otherwise with respect to, the Program, unless arising from the gross negligence of the Coach.

CONFIDENTIALITY

The Coach will keep the Client's information private, and will not share the Client's information to any third party unless compelled to by law.

ACKNOWLEDGEMENT

I accept the terms and conditions of this disclaimer. I acknowledge that any and all information given to me by Clear Rivers Holistics and Kori Caskey is to be used for educational purposes only. I also acknowledge that neither Clear Rivers Holistics, nor Kori Caskey claim to be medical doctors and will not prescribe for or diagnose any disease or condition. I also understand that Kori Caskey does not bill insurance companies and that it is my responsibility to pay by credit card, check or cash in full or at the time of service. I further understand that I must give 48 hours notice to cancel an appointment or I will be held financially responsible for the appointment.

The preceding answers are true and correct to the best of my knowledge. If I experience any changes in my health or current medications, I will immediately communicate this information to Clear Rivers Holistics and Kori Caskey. I further acknowledge that I am fully responsible for any decisions and/or changes I make regarding my health and I will not hold Clear Rivers Holistics or Kori Caskey liable for my own decisions, any results of my decisions or of any natural treatment or advice I may receive.

Client Name (print)

Client Signature

Date