First Visit Questionnaire

Personal Information

Name____

Street Address ____

City, Province, Post code____

Phone: ____________________________________ Home ___________________________________

Cell ______________________________________ Email___________________________________

____ Male ____ Female Age_________ Birth of Date ______________________________

Marital Status______________________________ Number and ages of children ___________________

Accompanied by ___________________________ Relationship_______________________________

Occupation or previous occupation if retired ____

Does your occupation require traveling? ___________ How often? _________________________

Daily Working Hours____

Days, weeks, months or years of macrobiotic practice? ___________________________________

What was your previous diet? ____

Approximate body weight ______________________ Height_____________________________

How is your bowel movement? ____

How many times a day do you urinate? ____

Color of urine: ______ Transparent ______ Dark yellow ______ Light Yellow

How were you referred ____

Cooking & Diet

Do you cook with: ______ Gas ______ Electricity ______ Microwave

Please check the foods you have been eating regularly, a few times a week.

____ Whole grain cereal

____ Fresh vegetables, cooked

____ Fresh vegetables, raw

____ Beans

____ Seaweed

____ Fruit

____ Fish

____ Nuts

____ Seeds

____ Vegetable oil

____ Meat

____ Poultry

____ Eggs

____ Dairy Food

____ Refined Flour Products

____ Canned Food

____ Frozen Foods

____ Sugar, honey, chocolate, carob

____ Artificial sweeteners, soft drinks

____ Spices, herbal teas

Present Concerns

What is the reason of your visit? Please specify such as: general dietary or lifestyle guidance; a specific health problem or illness; or a psychological problem**?** ____

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If you have a **particular disorder,** what is it diagnosed?

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Are you presently under the care of a doctor or other health professional? If yes, please specify.

____

Are you currently receiving any medical treatments? If yes, please specify: ___________________________

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Are you currently taking any medications, vitamins or supplements? If yes, please list below.

____

At the present time, do you experience any of the following **symptoms?**

___ Allergies ___ Fatigue ___ Nausea ___ Loss of Appetite

___ Visual problems ___ Disturbed sleep ___ Diarrhea ___ Constipation

Do you have any **pain?** Yes/No _____________________ If so, where? ______________________________

Time of day or night when pain occurs? ____

How would you describe the pain? ___ Dull ___ Sharp ___ Ache

Other ____

Do you experience any **bleeding** from: ___ Nose ___ Gums

Other ____

Would you describe your **lifestyle** as: ___ Peaceful ___ Stressful

If stressful, what do you perceive as the source of stress?

___ Family ___ Profession ___ Relationships with others ___ Economic situation

Other ____

Are you a frequent traveler? ___ Yes ___ No

Have you lived in other countries or climates ___ Yes ___ No

If so, where? ____

____

For how long? ____

For Women:

Are your menstrual cycles regular? ____

How many days in between periods? ____

How many days does it last? ____

Do you feel pain or discomfort? If so, when: ____ Before ____ During

Do you have vaginal discharge? ____

What type of birth control do you use? ____

If you have children, did you have normal childbirth? ____________________________________

Any other Comments:

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Health History

In chronological order, please list a brief health history. Include all diagnoses, surgeries (including tonsils, appendix, abortions, etc.) as well as medical treatment such as radiation and chemotherapy.
Please include any miscarriages, accidents or broken bones.

Date	Description	Doctors or Hospital Location

By signing this form, you agree that you have read thoroughly that the opinions, advice and services we offer are primarily educational and not medical advice and under no circumstances are to be considered by me as such;

(i) **The opinions, advice and services that you offer are under no circumstances intended to modify, affect, or to be in lieu of any medical advice or treatment that I may require for any cause whatsoever, now or in the future.**

(ii) You encourage me to consult with my doctor with reference to my particular problem and keep my doctor fully informed as to the opinions, advice and services you offer;

(iii) Your opinions, advice and services fundamentally relate to an educational program with respect to the teaching of a macrobiotic diet, nutrition, foods and related principles which many people have found helpful for improving one's physical, mental and spiritual conditions, and thus attain a "healthy way of life";

(iv) You have made no promises or representations, expressed or implied, as to any result I might obtain by adhering to your opinions, advice and services.

(v) I, together with any and all accompanying persons, have completely read the above statements, and acknowledge that I fully understand them, and that I have received no promises of guarantees whatsoever.

In witness whereof, I here unto set my hand that ____________ day of ______________________, 20____.

Client: ____ (Please print name)

____ _____________________________________

Client's Signature (Parent/Guardian if under the age of 18) | Witness to Signature

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