

## Denver Nutrition, LLC - New Client Questionnaire

*Welcome to Denver Nutrition, LLC. My approach requires me to have a thorough understanding of your health history to determine underlying causes affecting your health. Please take your time to complete this form – carefully and thoroughly. The more detailed and accurate you are, the more I will be able to help you achieve your health goals. All of the information herein will be treated in accordance with all applicable confidentiality laws and practices and is intended solely for the use of Debbie Allen, Denver Nutrition, LLC.*

### Introduction

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Phone/work \_\_\_\_\_ Cell: \_\_\_\_\_ Home: \_\_\_\_\_

Which phone is best to leave a message? Cell  Home

YES - Please add me to your newsletter list  NO

*(The newsletter is a source of complementary health news. We will not sell or share your info with any third party and will not SPAM your inbox with frequent messages.)*

Age: \_\_\_ Height: \_\_\_ Weight: \_\_\_ Sex: \_\_\_ Blood Type: \_\_\_ Birth date: \_\_\_\_\_

Marital Status: [ ] M [ ] S [ ] W [ ] D [ ] Other Occupation: \_\_\_\_\_

Birthplace: \_\_\_\_\_

Spouse/Partner Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

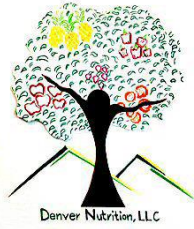
Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_

Referred by / Source: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_



**Please answer each of the following questions.**

*Please use the back of the page for additional space.*

1. If you could wave your magic wand and get whatever you want from our work together what would that be?

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2. Why are you here? What do you want to resolve?

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3. What's the biggest challenge for you around having this concern?

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4. How long have you had this issue?

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5. What was happening in your life around the time that this started?

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6. What do you think has caused or contributes to this problem?

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7. Have you seen any other professionals for help?

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8. Have you been diagnosed by a doctor with an ailment related to your main health concern(s)?

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9. What was their diagnosis?

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10. What strategies have you tried so far to help yourself?

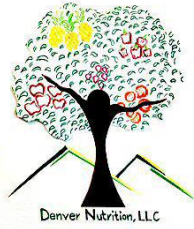
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11. What happened?

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12. Any other symptoms or health challenges that I should know about?

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13. Medications?

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14. Supplements?

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15. When do you tend to feel best?

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16. When do you tend to feel worse?

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17. How would life be different for you if you didn't have this challenge?  
What would your life look like?

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18. If this challenge was here to teach you a higher lesson, something deeper,  
what do you think that would be?

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19. Where do you work? Ideal job? Travel? What do you do?

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20. What is your family of origin? Parents, siblings? Heritage?

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21. Any significant partner, spouse, roommates?

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22. Are you...in a relationship, dating, dreams, and desires?

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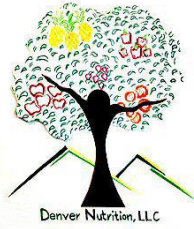
23. Do you have kids? Ages, names. Tell me about them.

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24. Pets? Do you have pet allergies?

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25. Do you vacation regularly? Yes \_\_\_ No \_\_\_



26. When was your last vacation? \_\_\_\_\_

27. Do you actively participate in any spiritual discipline?  
(church, religious group, meditation, etc.) Yes \_\_\_ No \_\_\_

28. What is YOUR "Purpose"?

\_\_\_\_\_

29. How is your money mgmt? Where you want it to be?

\_\_\_\_\_

30. What part of town do you live in? Like it?

\_\_\_\_\_

31. What do you want most in life?

\_\_\_\_\_

\_\_\_\_\_

**Dietary Intake - Let's talk about food :-)**

1. How many times a day do you eat:  
Main Meals \_\_\_\_\_ Times of day: \_\_\_\_\_  
Snacks \_\_\_\_\_ Times of day: \_\_\_\_\_

2. Who do you eat meals with? \_\_\_\_\_  
Family \* Home \* Alone \* on the run \* restaurant \* fast food

3. Do you feel there are restrictions to your diet due to the preferences of others:  
Family, roommates, etc? Yes \_\_\_ No \_\_\_ If yes, please explain

\_\_\_\_\_

4. Do you like eating?

\_\_\_\_\_

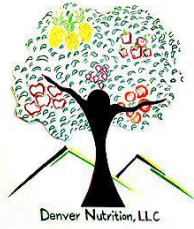
5. Are you a fast eater moderate eater or slow eater?

\_\_\_\_\_

6. What are your favorite foods?

\_\_\_\_\_

• *Let go of reaction or judgment - Tell everything – it's ok*



7. How many hours on average do you sleep daily? (Including naps) \_\_\_\_\_

8. What time do you go to sleep? \_\_\_\_\_ Awaken? \_\_\_\_\_

9. Do you awaken feeling rested? Yes \_\_\_ No \_\_\_

10. How often do you travel?  
\_\_\_\_\_

12. What do you mean by a cup of coffee - how big is the cup?  
\_\_\_\_\_

13. Anything else? What did we miss?  
\_\_\_\_\_

"How is it for you to answer all these questions about what you eat?"  
\_\_\_\_\_  
\_\_\_\_\_

Comments:  
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