WHITNEY OWEN, LMT, CHC

MASSAGE THERAPY & HEALTH COACHING

SUPPLEMENT PLAN QUESTIONNAIRE

This form asks some personal questions. I promise to keep all your information confidential. I also promise not to judge you.

You may fill this out using a PDF editor and email it to me at WHITNEY@WHITNEYOWEN.COM. You may also print it, fill it out, scan your answers, and email it to me. Or you may simply send me an email with the questions answered by number.

1. Client Name:

2. Today's Date:

3. Age:

4. Email:

5. Gender:

6. List any Medications/Multi-vitamins/Supplements, etc. you are taking:

7. What are your goals?

8. Does your tongue have a white coating on it?

9. Do you have any medical information/hormone issues/depression/etc. you would like to share with me?

10. Do you have any known or suspected thyroid Issues?

11. Do you experience any of the following?:

	YES	NO
migraines		
high blood pressure		
always feel cold		
swollen eye lids		
water retention		
thinning outer eyebrow		
constipation		
sensation of bump in throat		
trouble swallowing		
hoarse voice		
low moods		

12. Have you had your Vitamin D levels checked? If so, when was it checked and what is it?

13. Do you experienced any of the following?:

	YES	NO
joint pain		
muscle pain		
MS		

Inability to lose weight even when strictly limiting calories?		
Fertility issues		
Diabetes		
Moods issues		

14. Have you had your iron (ferritin) level checked? If so, when was it checked and what is it?

15. Females:

	YES	NO
Do you experience PMS?		
Do you experience excess facial hair?		
How Many days is your menstrual cycle?		

16. Males: Do you experience low sex drive or erectile dysfunction? Yes No

17. What are your FASTING blood glucose levels (if you know)?

18. What are your triglycerides (if you know from a cholesterol test)?

19. Do you have a bowel movement every day?

20. Do you experience indigestion or acid reflux?

21. Have you taken or are you taking acid blockers?

22. Do you feel tired or energetic after you eat?

23. Do you experience intense food cravings?

24. Do you bruise easily?

25. Describe any sleep issues you experience.

26. Do you frequently experience bloating?

27. Do you have any issues with your fingernails, such as thin or flat nails, white spots on nails, or ridges on nails?

28. What type of water do you drink?

29. How often do you use a hot tub or swimming pool?

30. Do you suffer from dry skin or dry eyes?

31. Do you scar easily or have slowly healing cuts?

32. Do you have calf, foot, or toe cramps while at rest?

33. Do you experience:

	YES	NO
Loss of vitality		
"brain fog"		
Sense of having to "fake" your energy		

34. Do your feet have a very strong odor?

35. Do you have cravings for substances other than food, such as paper, dirt, clay, rubber, or ice?

36. Do you have frequent yeast or fungal infections?

37. Do you have high blood pressure or cardiac arrhythmia?

38. Do you experience any of the following?:

	YES	NO
Excessive thirst		
Extreme hunger (even after eating)		
Nausea and possible vomiting		
Unusual weight gain or loss		
Increased fatigue		
Irritability		
Blurred vision		
Slow healing of wounds		
Frequent infections (skin, urinary, vaginal)		
Numbness or tingling in hands and/or feet		

39. Is there anything else you would like to tell me?