

## Client History Questionnaire

“Qigong is letting go of the things that deviate us from growing and being in a place of **loving self-empowerment**. It is fine **tuning the life force energy (chi)** within the self, so that one can live in their **highest quality of life**. It is diving deep to what feels right, not just for ourselves, but for all of humanity and the world in which we live in. We **thank you** for taking the time to provide us this important information about yourself.”

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

**My Main Reason for Treatment** \_\_\_\_\_

**Domestic/Living Situation** (own/rent, partner, children, pets, caregiving, etc.) \_\_\_\_\_

### Lifestyle

Work: Shift begins \_\_\_\_AM/PM Shift ends \_\_\_\_AM/PM

Recreation/Frequency: \_\_\_\_\_

Community: \_\_\_\_\_

Caffeine: Coffee \_\_\_\_cups/day Tea \_\_\_\_cups/day Soda \_\_\_\_cans/day  
Alcohol: \_\_\_\_\_/day Cigarettes/cigars: \_\_\_\_/day

### Sleeping Pattern

Usual bedtime \_\_\_\_AM/PM Usual wake time \_\_\_\_AM/PM

Number of awakenings \_\_\_\_\_ Naps per week \_\_\_\_\_

#### Please check all that apply to you:

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Fall asleep initially without difficulty | <input type="checkbox"/> Feel refreshed after naps           | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fall asleep inappropriately              | <input type="checkbox"/> Awaken long before it is necessary  | _____                                 |
| <input type="checkbox"/> Don't feel tired at bedtime              | <input type="checkbox"/> Difficulty waking in the morning    | _____                                 |
| <input type="checkbox"/> Have difficulty going back to sleep      | <input type="checkbox"/> Feel refreshed on awakening         | _____                                 |
| <input type="checkbox"/> Indigestion/heartburn while asleep       | <input type="checkbox"/> Feel groggy/foggy on awakening      | _____                                 |
| <input type="checkbox"/> Loud and disruptive snoring              | <input type="checkbox"/> Feel tired and fatigued while awake |                                       |
| <input type="checkbox"/> Snoring is worse on back                 | <input type="checkbox"/> Sore throat on awakening            |                                       |
| <input type="checkbox"/> Stop breathing during sleep              | <input type="checkbox"/> Have headaches on awakening         |                                       |
| <input type="checkbox"/> Restless sensation in legs               | <input type="checkbox"/> Wake up gasping for air             |                                       |
| <input type="checkbox"/> Leg jerks during sleep                   | <input type="checkbox"/> Awaken and feel paralyzed           |                                       |
| <input type="checkbox"/> Kicking or twitching during sleep        | <input type="checkbox"/> Muscle stiffness when first awake   |                                       |
| <input type="checkbox"/> Grind teeth in sleep                     | <input type="checkbox"/> Joint pain when first awake         |                                       |
| <input type="checkbox"/> Sleep talk                               | <input type="checkbox"/> Jaw aches in the morning            |                                       |
| <input type="checkbox"/> Sleep walk                               | <input type="checkbox"/> Sudden awakening w/ intense emotion |                                       |
| <input type="checkbox"/> Bed partner disturbs sleep               |  |                                       |

**Medical History.** Please check all that apply to you:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Hypertension    | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other Heart Issue: _____ |
| <input type="checkbox"/> Chest Pain      | <input type="checkbox"/> Chronic Cough         | <input type="checkbox"/> Sputum with Cough        |
| <input type="checkbox"/> Lung Illness    | <input type="checkbox"/> Short of Breath       | <input type="checkbox"/> Asthma/Respiratory Issue |
| <input type="checkbox"/> Digestion Issue | <input type="checkbox"/> Hiatus Hernia         | <input type="checkbox"/> Other GI Issue: _____    |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Anemia/Blood Disorder | <input type="checkbox"/> Auto-immune Issue        |
| <input type="checkbox"/> Cognitive Issue | <input type="checkbox"/> Seizures              | <input type="checkbox"/> Neurological Problems    |
| <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Depression            | <input type="checkbox"/> Swelling of Feet         |
| <input type="checkbox"/> Menstrual Issue | <input type="checkbox"/> Libido Issue          | <input type="checkbox"/> Over/Under Weight        |
| <input type="checkbox"/> Other: _____    |  |   |

Surgeries: \_\_\_\_\_

Environmental Allergies: \_\_\_\_\_

Chemical Allergies: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

**Medications/Supplements**

Name	Dosage	Times Taken
_____		
_____		
_____		

**Family History** (ethnicity, parentage, brothers, sisters, their ages, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Experience in Managing Stress** (relaxation/meditation techniques, exercise, gardening, quiet time/space, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please complete prior to, and return this form at your next visit.**

**Feel free to contact us with any questions that arise.**

**Alpine Leinad Pla**

Certified Medical Qigong Practitioner & Licensed Massage Therapist

UNIVERSAL SELF ATTUNEMENT



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## Chi Nutrition Questionnaire

Sometimes, it is helpful in our clients' healing and empowerment process to include some amount of focus on **“Chi Nutrition”**, bringing the balance of yin and yang qualities of the chi through our food and supplementation. This can contribute to as much 33-34% of your health improvement. As such, thank you for taking the time to answer the following questions as accurately as possible.

Please check all of the following **nutritional practices** with which you are familiar:

ChiNutrition       5 Flavors       Food Sequencing  
 FoodCombining     Vegan               Juicing

Do you have any regularly occurring digestive, metabolic or waste elimination difficulties that you did not identify in your Client History Questionnaire? If “yes”, please describe:

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### Flavors

Check the flavor(s) you often crave:

Sour       Bitter       Sweet       Mildly Spicy       Very Spicy       Salty

Of the flavors you have checked, **circle** the one flavor you crave the most?

How often in a day do you eat each of the flavors you checked above:

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Please provide examples of each of the flavors you have identified:

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### Meals

On a typical work day, what do you eat and what time do you usually eat them?

Meal	Time	Food Items
Breakfast		
Lunch		
Dinner		

Snack #1		
Snack #2		
Other		

Are there any days in the week that you stray from this meal plan? For example, are any of your weekend meals drastically different? If “yes”, please describe:

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**Relevant Health Issues**

Do you have any food or supplement allergies? If “yes”, please describe, and tell us what happens when you eat them:

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**Beyond what you have already identified in your Client History Questionnaire and this one**

Have you been clinically diagnosed, or otherwise seem to struggle with, **headaches, light-headedness, dizziness and/or any neurological or behavioral health issues or symptoms?** If “yes”, please describe, and if you have received a clinical diagnosis relating to this issue, state the diagnosis and when it was diagnosed by a medical professional:

Health Issues	When Does It Start? How Long Does It Last? How Frequently?	Name of Diagnosed Condition	Date Clinically Diagnosed

**Check all of the following symptoms that you experience on a regular or ongoing basis:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Easily Fatigued   | <input type="checkbox"/> Balance Difficulties        | <input type="checkbox"/> Scattered or Chaotic Energy |
| <input type="checkbox"/> Confused/Muddled Thinking                                     | <input type="checkbox"/> Menstrual Issue             | <input type="checkbox"/> Poor Focus/Concentration    |
| <input type="checkbox"/> Tired Eyes  | <input type="checkbox"/> Over/Under Weight           | <input type="checkbox"/> Swelling Anywhere in Body   |
| <input type="checkbox"/> Frequent Coughing   | <input type="checkbox"/> Anxious                     | <input type="checkbox"/> Difficulty Breathing        |
| <input type="checkbox"/> Dry Throat  | <input type="checkbox"/> Worried                     | <input type="checkbox"/> Dry Skin                    |
| <input type="checkbox"/> Excessive Hair Loss   | <input type="checkbox"/> Can't Feel/Express Emotions | <input type="checkbox"/> Joint Aches/Stiffness       |
| <input type="checkbox"/> Spine Ache/Stiffness  | <input type="checkbox"/> Nausea/Vomiting             | <input type="checkbox"/> Cold Hands/Feet             |
| <input type="checkbox"/> Thirst/Dry Mouth  | <input type="checkbox"/> Excessive Appetite          | <input type="checkbox"/> Libido Issue                |
| <input type="checkbox"/> Poor, or Lack of, Appetite                                    | <input type="checkbox"/> Digestive Gas/Bloating      | <input type="checkbox"/> Frustrated/Angry            |
| <input type="checkbox"/> Overheated in Body  | <input type="checkbox"/> Chills                      | <input type="checkbox"/> Sad/Depressed               |
| <input type="checkbox"/> Ruddy Complexion  | <input type="checkbox"/> Thin/Weak Finger/Toe Nails  | <input type="checkbox"/> Fearful                     |
| <input type="checkbox"/> Other (not identified anywhere else in these questionnaires): |  |  |

Do you have any concerns relating to your body's ability to digest foods, metabolize nutrients and eliminate waste? If "yes", please share your concern with us:

Do any of your father, mother, stepparents, siblings, step-siblings, children and/or children have nutritional concerns similar to any of yours? If "yes, please identify who they are and what the concerns are:

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