Community Health Stores
Free Health Consultation

In Store - 10-15 Min

Consultant: ____________________ Date: ____________________

Client Details

Name: ____________________

Male / Female

Contact Phone: ____________________ Age: ____________________

Email: ____________________

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1. What is the main health concern you would like to discuss today?

2. How long have you been experiencing this problem and how is it affecting you?

3. Have you seen other health practitioners or specialists about this health concern?

4. How well are you sleeping? Please rate your sleep from 1-10 (10 is extremely poor quality of sleep)

5. What level of stress are you experiencing? Please rate this from 1-10 (10 is extremely high levels of stress)

6. Do you have good gut health? Please rate this from 1-10 (10 is extremely poor digestive health)

7. Do you have a healthy eating and exercise plan? Would like more help in these areas?

8. Do you get coughs and colds regularly?

9. What supplements are you currently using / What supplements have you tried before?

10. Are you taking any prescription medication?

11. Do you have any allergies/intolerance's?

12. Are you pregnant or breast feeding?

The information and other content provided in this questionnaire, or in any linked materials, are not intended and should not be construed as medical advice, nor is the information a substitute for professional medical expertise or treatment.
If you or any other person has a medical concern, you should consult with your health care provider or seek other professional medical treatment. Never disregard professional medical advice or delay in seeking it because of something that you have read on this questionnaire or in any linked materials. Always read the label and use products as directed.

Community Health Stores Health Plan

Health Plan

Diet and Lifestyle

Supplement Program

(CHS stores choose products that are of high quality with raw ingredients that can be traced to source)

Referral to Health practitioners

Review date: ____

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