

Your Background

First Name: _____ Last Name: _____ Date _____

Address: Street _____ Phone (H): _____

City _____ State _____ Zip _____ Phone (W): _____

Age: _____ Birthdate: _____ Sex: _____ Height: _____ Weight: _____ Phone (C): _____

Occupation: _____ Email: _____ Fax: _____

Referred by (name, relationship to you): _____

Alternate Contact (name, phone, relationship to you): _____

Primary Doctor: Name: _____ Phone: _____

Address: _____

Permission to contact?: Yes / No

Your Current Health Concerns & Symptoms

How did they begin?: _____

When did they begin?: _____

Please describe them (attach extra pages if necessary): _____

Have you seen a doctor for these issues? Yes / No

If so, what was the diagnosis? _____ Age diagnosed? _____

Have you seen other health practitioners for these issues? Yes / No

If so, what type (e.g., chiropractor, accupuncturist, other nutritionist, etc.)?: _____

Your Goals - Please describe your health goals and what you'd like nutrition counseling to help you to achieve:

Your Medical History

For your current condition/s:

What have you done that's helped?

What have you done that's not helped?

Any known medication allergies? (e.g., aspirin, Tylenol) _____

Current Medications (please include condition - e.g., Prilosec for ulcer, Premarin for hormone replacement):

Current Supplements (please include form, dose, & frequency - e.g., zinc citrate - 15 mg twice per day):

Surgeries (please list any past or planned surgeries)

Procedure

Date

Recent weight changes? Yes / No

If so, please describe timing and amount (e.g., 20 lb. gain over last 6 mos.): _____

Health History - You and Your Family

1. Please indicate whether you or close family members have been affected by these conditions.
2. For yourself, please indicate whether you currently have the condition or had it in the past by marking the appropriate column (C - current; P - Past)
3. For other family members, please use these initials as they relate to **you** (e.g., M = your mother):

M - mother S - son B - brother MGM - maternal grandmother PGM - paternal grandmother
 F - father D - daughter Si - sister MGF - maternal grandfather PGF - paternal grandfather

| Condition | You | | Family member/s |
|--------------------------|-----|---|-----------------|
| | C | P | |
| Diabetes - Type 1 | | | |
| Diabetes - Type 2 | | | |
| Hypoglycemia | | | |
| Obesity | | | |
| Stroke | | | |
| High blood pressure | | | |
| | | | |
| Osteoporosis | | | |
| Osteoarthritis | | | |
| Rheumatoid arthritis | | | |
| | | | |
| Allergies | | | |
| Asthma | | | |
| Chronic congestion | | | |
| | | | |
| Insomnia | | | |
| | | | |
| Hypothyroid | | | |
| Hyperthyroid | | | |
| | | | |
| Chronic fatigue | | | |
| Fibromyalgia | | | |
| | | | |
| Cataracts | | | |
| Glaucoma | | | |
| Macular degeneration | | | |
| | | | |
| Hearing loss | | | |
| Loss of smell | | | |
| Loss of taste | | | |
| | | | |
| Kidney stones | | | |
| Prostate problems | | | |
| Urinary tract infections | | | |
| | | | |
| Lupus | | | |
| Multiple Sclerosis | | | |
| | | | |
| Gout | | | |

| Condition | You | | Family member/s |
|---------------------|-----|---|-----------------|
| | C | P | |
| Cancer (list type) | | | |
| | | | |
| Celiac disease | | | |
| Crohn's disease | | | |
| Diverticulosis/itis | | | |
| Gallstones | | | |
| Irritable bowel | | | |
| Liver disease | | | |
| Ulcer | | | |
| Ulcerative colitis | | | |
| | | | |
| Athlete's foot | | | |
| Jock itch | | | |
| Yeast infection | | | |
| | | | |
| Eczema | | | |
| Psoriasis | | | |
| Rashes | | | |
| | | | |
| ADD/ADHD | | | |
| Asperger's syndrome | | | |
| Autism | | | |
| Down's syndrome | | | |
| Dyslexia | | | |
| Learning disability | | | |
| OCD | | | |
| | | | |
| Alzheimer's | | | |
| Parkinson's | | | |
| | | | |
| Alcoholism | | | |
| Drug addiction | | | |
| | | | |
| Anorexia | | | |
| Bulimia | | | |
| | | | |
| Anxiety | | | |
| Bipolar disorder | | | |
| Depression | | | |

Any other conditions not listed above? Please describe:

| Condition | You | | Family member/s |
|-----------|-----|---|-----------------|
| | C | P | |
| | | | |
| | | | |
| | | | |
| | | | |

| Condition | You | | Family member/s |
|-----------|-----|---|-----------------|
| | C | P | |
| | | | |
| | | | |
| | | | |
| | | | |

Any conditions that run in the family? (e.g., diabetes, autoimmune disease, etc.): _____

Any family members in your home smoke? Drink?: _____

Vital Signs & Lab Test Results

1. Please indicate the most recent date that you have had your vital signs measured and/or the lab tests below performed.
2. Please list any other relevant tests not included below.
3. Please include copies of your vital sign records and lab test results when you fax or mail your information in advance of the scheduled appointment.

| Test | Description | Date |
|-----------------------------|--|------|
| Vital Signs | pulse, blood pressure, body temperature | |
| Blood Lipids | total cholesterol, LDL, HDL, triglycerides, etc. | |
| Fasting Blood Glucose | | |
| Hemoglobin A1C | | |
| Complete Blood Count (CBC) | WBC - count & differential, RBC, Hgb, Hct, MCV, platelet count, etc. | |
| Chemistry (Metabolic) Panel | BUN, creatinine, liver enzymes, electrolytes, etc. | |
| Thyroid Panel | TSH, T3, T4, free T3, free T4 | |
| Iron Panel | ferritin, TIBC, serum, etc. | |
| Homocysteine | | |
| C-Reactive Protein | | |
| Other (please list) | (e.g., fibrinogen, porphyrins, RBC elements, hair test) | |
| | | |
| | | |
| | | |

Lifestyle History

Smoke? yes / no If yes: packs per day _____ number of years _____

Drink? yes / no Type: beer / wine / other _____ Drinks/day _____ Drinks/week _____

Exercise? yes / no Type (please describe): _____

Duration (e.g., 45 mins.): _____ Frequency (# times / week): _____

Stress - Please rank from 1 (very low) to 5 (high)

Work _____ Home _____ Relationships _____ Illness _____

Clinical Observations

Hair

- Recent change in condition? no / more dry / more oily
- Recent increase in loss? yes / no
- Recent change in color? yes / no
- Easily plucked? yes / no
- Dandruff? yes / no

Skin

- Recent change in condition? no / more dry / more oily
- Eczema? If so, where? _____ When appeared? _____
- Rash? If so, where? _____ When appeared? _____

Nails

- Condition - soft / brittle / normal
- Hangnails? yes / no
- Visible lines? horizontal / vertical When first appeared? _____
- Nail bed color? pink / white / red
- Fungal infections? no / feet / hands

Mouth

- Lips dry/cracked? yes / no
- Tongue - normal / smooth / cracked / red / sore / coated / other _____
- Breath - normal / slightly bad / bad
- Taste - normal / metallic / sour
- Do you have amalgam ("silver") fillings? yes / no If so, how many? _____
- Do you have gum disease? yes / no
- Do your gums bleed? yes / no

Neurologic

- Recent change in:
 - Memory? yes / no Concentration? yes / no Ability to recall words? yes / no
 - Sociability? yes / no Coordination? yes / no
- Headaches? yes / no
 Frequency _____ Strength _____ Location _____
- Irritable, short-tempered? yes / no Fearful? yes / no Depressed? yes / no
- Anxious, nervous? yes / no Weepy? yes / no Sensitive to noise? yes / no
- Restless legs? yes / no

Energy Level

- How would you describe your overall energy level? 1 to 5, with 1 very low and 5 high _____
- Are you easily fatigued? yes / no
- Do you have difficulty waking up in the morning, not feeling refreshed? yes / no
- Are you tired during the day? If so, at what times? _____
- Do you feel your best at night? yes / no
- Are you dizzy or light-headed upon standing from a sitting or lying position? yes / no
- Do you become confused, shaky, or freeze when under stress? yes / no

Temperature

- Are your feet and/or hands often cold? feet / hands / neither
- Are you sensitive to cold? yes / no Heat? yes / no
- Do you perspire - A lot? An average amount? A little? Not at all?

Sleep

- Average # hours per night _____ Go to sleep at _____ Wake at _____
- Go to sleep and wake at the same time each day? yes / no
- # of times you get up during the night? none / 1x / 2x / 3x / other _____
Reason/s: Can't sleep / bathroom / other _____

Females

- Period - normal / absent / irregular (please explain) _____
PMS, cramps, other issues? _____
- Pregnant? - no / current / want to be
- # of pregnancies _____ Births _____ Children _____
- Hotflashes? yes / no If yes, frequency? duration? _____
- Taking HRT? yes / no Bio-identical hormones? yes / no
- Get up during the night to urinate? yes / no If yes, # of times? _____
- Libido? low / normal / high / none

Males

- Get up during the night to urinate? yes / no If yes, # of times? _____
- Difficulty with erections? yes / no If yes: rarely sometimes frequently
- Libido? low / normal / high / none

Environmental Exposures

- Have you received any vaccinations in the last several years? yes / no If so, please list:

Vaccination

Date

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

- Do you use pesticides either in or outside your home? yes / no

If so, please list: _____

- Are you sensitive to:

- Fragrances? yes / no - Car fumes? yes / no - Cigarette smoke? yes / no

- Chemicals/ cleaners? yes / no Please list _____

- Have you been exposed to any chemicals:

At past jobs? yes / no Please list _____

At your current job? yes / no Please list _____

- Have you had any work done on your home or apartment recently? (e.g., new flooring, painting, remodeling)

If so, please describe: _____

- Do you or have you ever had a problem with mold in your home? If so, please describe: _____

- Do you live near a known source of environmental pollution (e.g., freeway, coal-fired power plant)? If so,

please describe: _____

Dietary History

meals you eat per day? _____

Water intake

Meal pattern Y / N / Sometimes

- at home - tap / filtered / bottled / distilled / other _____

- Eat breakfast? _____

- away from home - tap / filtered / bottled / distilled /
other _____

- Eat lunch? _____

- amount per day (oz.) _____

- Eat dinner? _____

- Snack (morning) _____

Drink coffee? yes / no # cups/day ____ caffeinated? ____

- Snack (afternoon) _____

Drink tea? yes / no # cups/day ____ caffeinated? ____

- Snack (evening) _____

Drink soda? yes / no diet / regular amount/day (oz.) ____
caffeinated? _____

Vegetarian (eat eggs & dairy)? yes / no

Vegan (no eggs & dairy)? yes / no

Other vegetarian type (please describe): _____

Eat fish? yes / no What types? _____ How often? _____

Favorite foods _____

Least favorite foods _____

Known food allergies / intolerances _____

Have you been tested for IgE or IgG antibodies to different foods? IgE / IgG / neither
(If yes to either, please include copies of test results when you fax or mail your information in advance of
the scheduled appointment.)

Do you add artificial sweeteners to foods or drinks? yes / no Which sweeteners? _____

Are you lactose intolerant? yes / no

Do you frequently experience heartburn or acid reflux? yes / no

Any recent change in your overall desire for food? no / increased / decreased

Do you crave specific types of foods? salty / sweet / fatty / other _____

Recent nausea or vomiting? yes / no

Recent changes in taste? yes / no In smell? yes / no Please describe _____

Feel full more or less quickly than usual? no / more quickly / less quickly

Any pain or discomfort when eating? If so, where? _____ When? _____

Any problems chewing or swallowing? yes / no Please describe _____

Any dental or oral problems making it difficult to eat? yes / no Please describe _____

Have you pursued diets in the past (e.g., Atkins, South Beach)? If so, please describe? _____

Have you ever had an eating disorder? yes / no

If yes, please describe (which disorder/s, age, duration, if you saw a medical professional for help, etc.) _____

Bowel Habits

of bowel movements per day? 1x / 2x / 3x / every other day / other _____

Do you frequently experience: Diarrhea? yes / no Constipation? yes / no Bloating or gas? yes / no

Stool Characteristics

Form: well-formed mushy watery frothy hard-pellets

Float or sink: float sink

Color: brown light brown green yellow black

Is there fat in the stool (i.e., sheen floating on top of the water)? yes / no

Is there blood in the stool? yes / no If so, what color? bright red / dark red / black

