Marc Joseph Nutrition **Client Information Questionnaire Adult** Last Name_____

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, acupuncturist, 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? _____

Meal pattern Y / N / Sometimes

- Eat breakfast? _____
- Eat lunch? _____
- Eat dinner? _____
- Snack (morning) _____
- Snack (afternoon) _____
- Snack (evening) _____

Water intake

- at home - tap / filtered / bottled / distilled / other _____
- away from home - tap / filtered / bottled / distilled / other _____
- amount per day (oz.) _____

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

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

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

Food Record - 3 Day

1. Please keep a daily food record of what you eat **and** drink on three (3) days that are representative of your average diet. Selecting two weekdays and one weekend day may be a useful way to do it.
2. Record only one food item per line. For example, if you have cereal with fruit and milk, put the cereal, fruit, and milk and their respective amounts on separate lines. If you have a sandwich, record the different ingredients (e.g., whole wheat bread, turkey - white meat, mustard, lettuce, tomato) on separate lines.
3. Be as specific as you can when describing the food item eaten. For example, the way it was cooked and the amount that was eaten.
4. Include brand names whenever possible.
5. Include condiments, oils used in cooking, added salt, etc.

Example

Time	Food Item & Method of Preparation	Amount Eaten
7 am	cereal, Raisin Bran	1 cup
7 am	Milk, non-fat	3/4 cup
7 am	Banana	1, medium
7 am	Coffee, caffeinated, black	8 oz.

Day 1 **Date_____**

Time	Food Item & Method of Preparation	Amount Eaten

Day 2 **Date_____**

Time	Food Item & Method of Preparation	Amount Eaten

Day 3 **Date_____**

Time	Food Item & Method of Preparation	Amount Eaten