Holistic Roots NUTRITION

Original Date:
Dates Revised:

NUTRITION INTAKE FORM

All questions contained on this form are strictly confidential

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Referring doctor or current GCP:	**Date of last physical exam:**
Address:	
Email:	**Phone:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
List top 5 health concerns/goals:	☐	☐
	☐	☐
	☐	

List any medical problems that other doctors/practictioners have diagnosed

Any Surgeries?

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Please turn to next page

List all medications/supplementation taken daily		
Name	Dose	Frequency Taken

Allergies to medications	
Name the Drug/Supplement/Food	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	What is your current diet? (vegetarian, vegan, Paleo, gluten-free, kosher, other)					
	Is your current diet working for you?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank veggie intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
	Rank animal protein intake	☐ Hi	☐ Med	☐ Low		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No	How many per week?		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda		
	# of cups/cans per day?					
Eating patterns:	Please check all that apply.					
	☐emotional eater	☐forget to eat				
	☐hungry all the time	☐eat out of boredom				
	☐late night snacker	☐don't eat breakfast				
	☐don't eat lunch	☐don't eat dinner				
	☐fast eater	☐eat in the car/at computer				
	☐make poor choices	☐don't out yourself first (family/kids hinder your ability to eat well)				
	☐I make healthy choices	☐I consider myself a healthy whole foods eater				

Tobacco	Do you use tobacco?				
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Do you use marijuana for medical or recreational use?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying to get pregnant?			☐ Yes	☐ No
	If not trying to get pregnant list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Family History

Do you or anybody in your family have the following conditions?

Alcoholism_____
Allergies_____
Arthritis_____
Autoimmune problems_____
Bone/skeletal problems_____
Brain/neurological problems_____
Cancer_____
Diabetes_____
Digestive/crohns/colitis_____
Eye/vision problems_____
Genital/reproductive problems_____
Heart Disease_____
High blood pressure_____
Intestinal problems_____
Kidney/bladder problems_____
Liver problems_____
Respiratory problems_____
Skin/eczema issues_____
Thyroid problems_____

Women Only

Please circle all that apply

Premenopausal (perimenopausal)
Regular periods (regular intervals)
Irregular periods (long or short)
Post-menopausal
Pregnant now
Trying to get pregnant
Currently taking the pill
Taken pill more than 12 months
Taking hormone replacement

EMOTIONAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Diet Diary: Please outline a typical day with regards to eating habits & symptoms**.**

Dietary Intake	**List any specific symptoms** (emotional/physical responses)
Wake time?	
Breakfast	
Lunch	
Dinner	
Snacks?	
Bed Time?	Bowel movements?

Eating Habits

Do you drink water? Y N How much per day? _____

List your favorite foods _____

List foods that you absolutely will not eat _____

Describe an average breakfast (Please be realistic) _____

Describe an average lunch _____

Describe an average dinner _____

Do you eat snacks during the day Y N If yes, at what times?_____

How often to you eat fish?_____How often to you eat nuts? _____
List 3 worst foods you eat during an average week_____
List 3 healthiest foods you eat during an average week_____

GENERAL SYMPTOMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Any Other Comments or Concerns you'd like to discuss:

METABOLIC ASSESSMENT FORM

Please circle the appropriate number 0-3 on all questions below. 0=least/never, 3=the most/always

Part I						**Part VI continued**				
Feeling that bowels do not empty completely	0	1	2	3		Excessive passage of gas	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3		Nausea &/or vomiting	0	1	2	3
Alternating constipation and diarrhea.	0	1	2	3		Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2	3
Diarrhea	0	1	2	3		Frequent urination	0	1	2	3
Constipation	0	1	2	3		Increased thirst and appetite	0	1	2	3
Hard dry small stool	0	1	2	3		Difficulty losing weight	0	1	2	3
Coated tongue, fuzzy debris on tongue	0	1	2	3		**Part VII**				
Pass large amounts of foul smelling gas	0	1	2	3		Greasy or high –fat foods cause distress	0	1	2	3
More than three bowel movements daily	0	1	2	3		Lower bowel gas or bloating several hours after eating	0	1	2	3
Use laxatives frequently	0	1	2	3		Bitter metallic taste in mouth especially in the morning	0	1	2	3
Part II						Unexplained itchy skinny	0	1	2	3
Increasing frequency of food reactions	0	1	2	3		Yellowish cast to eyes	0	1	2	3
Unpredictable food reactions	0	1	2	3		Stool color alternates from clay colored to dark brown	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3		Reddened skin, especially palms	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3		Dry or flaky skin or hair	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3		History of gallbladder attacks or stones	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3		Have you had your gallbladder removed		yes	no	
Part III						**Part VIII**				
Intolerance to smells	0	1	2	3		Acne and unhealthy skin	0	1	2	3
Intolerance to jewelry	0	1	2	3		Excessive hair loss	0	1	2	3
Intolerance to shampoos, lotion, detergents, etc.	0	1	2	3		Overall sense of bloating	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3		Bodily swelling for no reason	0	1	2	3
Constant skin outbreaks	0	1	2	3		Weight gain	0	1	2	3
Part IV						Poor bowel function	0	1	2	3
Excessive belching, burping or bloating	0	1	2	3		Excessively foul-smelling sweat	0	1	2	3
Gas immediately following a meal	0	1	2	3		**Part IX**				
Offensive breath	0	1	2	3		Crave sweets during the day	0	1	2	3
Difficult bowel movements	0	1	2	3		Irritable if meals are missed	0	1	2	3
Sense of fullness during or after meals	0	1	2	3		Depend on coffee to keep yourself going or started	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3		Get lightheaded if meals are missed	0	1	2	3
Part V						Eating relieves fatigue	0	1	2	3
Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3		Feel shaky, jittery, or have tremors	0	1	2	3
Use antacids	0	1	2	3		Agitated, easily upset, nervous	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3		Poor memory/forgetful	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3		Blurred vision	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3		**Part X**				
Digestive problems subside with rest & relaxation	0	1	2	3		Fatigue after meals	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol & caffeine	0	1	2	3		Crave sweets during the day	0	1	2	3
Part VI						Sweets don't relieve sugar cravings	0	1	2	3
Roughage and fiber cause constipation	0	1	2	3		Must have sweets after meals	0	1	2	3
Indigestion & fullness lasts 2-4 hours after eating	0	1	2	3		Waist is equal or larger than hip girth	0	1	2	3
Pain & soreness on the left side under rib cage	0	1	2	3		Frequent urination	0	1	2	3

Part X continued						**Part XV**				
Increased thirst and appetite	0	1	2	3		Heart palpitations	0	1	2	3
Difficulty losing weight	0	1	2	3		Inward trembling	0	1	2	3
Part XI						Increased pulse even at rest	0	1	2	3
Cannot stay asleep	0	1	2	3		Nervous and emotional	0	1	2	3
Crave salt	0	1	2	3		Insomnia	0	1	2	3
Slow starter in the morning	0	1	2	3		**Part XVI**				
Afternoon fatigue	0	1	2	3		Diminished sex drive	0	1	2	3
Dizziness when standing up quickly	0	1	2	3		Menstrual disorders or lack of menstruation	0	1	2	3
Weak nails	0	1	2	3		Increased ability to eat sugars Without symptoms	0	1	2	3
Part XII						**Part XVII**				
Cannot fall asleep	0	1	2	3		Increased sex drive	0	1	2	3
Perspire easily	0	1	2	3		Tolerance to sugars reduced	0	1	2	3
Under high amounts of stress	0	1	2	3		"Splitting" type headaches	0	1	2	3
Weight gain when under stress	0	1	2	3		**Part XVIII (MALES ONLY)**				
Wake up tired even after 6 or more hours of sleep	0	1	2	3		Urination difficulty or dribbling	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3		Frequent urination	0	1	2	3
Part XIII						Pain inside of legs or heels	0	1	2	3
Edema and swelling in ankles and wrists	0	1	2	3		Feeling incomplete bowel emptying	0	1	2	3
Muscle cramping	0	1	2	3		Leg twitching at night	0	1	2	3
Poor muscle endurance	0	1	2	3		**Part XIX (MALES ONLY)**				
Frequent urination	0	1	2	3		Decreased libido	0	1	2	3
Frequent thirst	0	1	2	3		Decreased number of spontaneous morning erections	0	1	2	3
Crave salt	0	1	2	3		Decreased fullness of erections	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3		Difficulty maintaining morning Erections	0	1	2	3
Alteration in bowel regularity	0	1	2	3		Spells of mental fatigue	0	1	2	3
Inability to hold breath for long periods	0	1	2	3		Inability to concentrate	0	1	2	3
Shallow, rapid breathing	0	1	2	3		Episodes of depression	0	1	2	3
Part XIV						Muscle soreness	0	1	2	3
Tired/sluggish	0	1	2	3		Decrease in physical stamina	0	1	2	3
Feel cold-hands, feet, all over	0	1	2	3		Unexplained weight gain	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3		Increase in fat distribution around chest and hips	0	1	2	3
Increase in weight even with low calorie diet	0	1	2	3		Sweating attacks	0	1	2	3
Gain weight easily	0	1	2	3		More emotional than in the past	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3		**Part XX (MENSTRUATING FEMALES ONLY)**				
Depression/lack of motivation	0	1	2	3		Perimenopausal	0	1	2	3
Morning headaches that wear off ask the day progresses	0	1	2	3		Alternating menstrual cycle lengths	0	1	2	3
Outer third of eyebrow thins Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3		Extended menstrual cycle (greater than 32 days)	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3		Shortened menses, less than every 24 days	0	1	2	3
Mental sluggishness	0	1	2	3		Pain and cramping during periods	0	1	2	3
Part XX menstruating females continued										
Scanty blood flow	0	1	2	3						
Heavy blood flow	0	1	2	3						
Breast pain and swelling during menses	0	1	2	3						
Pelvic pain during menses	Yes	No								
Irritable and depressed during menses	Yes	No								
Acne breakouts	Yes	No								
Facial hair growth	Yes	No								
Hair loss/thinning	0	1	2	3						
Part XXI (MENOPAUSAL FEMALES ONLY)										
How many years have you been Menopausal?	____	years								

Since menopause, do you ever have uterine bleeding?	Yes	No								
Hot flashes	0	1	2	3						
Mental fogginess	0	1	2	3						
Disinterest in sex	0	1	2	3						
Mood swings	0	1	2	3						
Depression	0	1	2	3						
Painful intercourse	0	1	2	3						
Shrinking breasts	Yes	No		3						
Facial hair growth	0	1	2	3						
Acne	0	1	2	3						
Increased vaginal pain, dryness or itching	0	1	2	3						