Client Nutrition Intake Form

Date___________

Information

Name____ Age______________

Address____

Phone (home) ___________________________ Phone (cell)_____________________________

Email____

Referred by____

MD/Other Health care practitioner info____

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Stats

Height _______ Current Weight ________ Ideal Weight ______ Weight 1 Year Ago______

Family/Living Situation ____

Occupation ____

List any **medications** you are currently taking:

List **vitamins**, minerals, herbs and other supplements (and amounts) you are now taking:

Health Concerns

What are your main health concerns? (Describe severity symptoms and when started):

<u>Please circle any of the following conditions that apply to your history and list date of onset:</u>

Anemia Arthritis Asthma Cancer Chronic fatigue Crohns or Ulcerative Colitis Diabetes Epilepsy Gallstones GERD/Reflux Gout Heart Attack Hepatitis High Cholesterol High Triglycerides High Blood Pressure Irritable Bowel Kidney Stones Mono Sinusitis Sleep Apnea Stroke Thyroid

OTHER:

How have you dealt with these concerns in the past? Doctors? Self Care? Any success?

Have you experienced any success with these approaches?

Have any other family members had similar problems (describe)?

How often have you had antibiotics in infancy/childhood/teen adult? What about steroids?

Nutritional Status

Are there any foods that you avoid? If so, why?

Do you have symptoms immediately after eating like bloating, gas, sneezing, hives? Explain

Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

Are there foods that you crave or even “binge” on?

Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time.

Which, if any, of the following foods do you consume regularly?

○ soda ○ diet soda ○ refined sugar (sugar, honey, sweets, candy) ○ alcohol ○ fast food
○ gluten (wheat, rye, barley) ○ dairy (milk, cheese, yogurt) ○ coffee ○ other

Do you feel better or worse eating certain types of foods?

What percentage of your meals are home-cooked?

Is there anything else I should know about your current diet, history, relationship to food?

Intestinal Status

Bowel Movement Frequency

○ more than 3 times per day ○ 2-3 times per day ○ once a day
○ not regularly every day (how many times per week)

Bowel Movement Consistency

1) Separate hard lumps, like nuts (hard to pass)
2) Sausage-shaped, but lumpy
3) Like a sausage but with cracks on its surface
4) Like a sausage or snake, smooth and soft
5) Soft blobs with clear cut edges (passed easily)
6) Fluffy pieces with ragged edges, a mushy stool
7) Watery, no solid pieces. Entirely liquid

Bowel Movement Color

○ medium brown
○ very dark or black
○ greenish
○ blood is visible
○ variable
○ yellow, light brown
○ chalky colored
○ greasy, shiny

Do you experience intestinal gas or any itching: If so, please explain if it is excessive, odorous, etc

Health Hazards

22. Have you been exposed to chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

23. Do odors affect you?

24. Are you or have you been exposed to second-hand smoke?

25. Do you have mercury amalgam fillings?

Lifestyle History – Sleep and Stress

Have you used or abused alcohol, drugs, meds, tobacco or caffeine?

Are you experiencing stress at this time in your life?

How do you handle stress?

Describe your sleep patterns. Can you get to sleep easily? Can you stay asleep? How many hours do you average per night?

What are your hobbies or leisure activities?

For Women Only

How are/were your menses? Do/did you have PMS? Painful periods: If so, explain.

In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

Have you experienced any yeast infections or urinary tract infections? Are they regular?

Have you/do you still take birth control pills: If so, please list length of time and type.

Have you had any problems with conception or pregnancy?

Mental Health Status

How are your moods in general? Do you experience more than you would like of anxiety? Depression? Anger?

On a scale of 1 (worst)-10 (best), describe your usual level of energy.

At what point in your life did you feel best? Why?

Other

Who in your family or on your health care team will be most supportive of you making dietary changes?

Please describe any other information you think would be useful in helping to address your health concern(s):

What are your health goals and aspirations?

SUPPLEMENTAL

1. **Please send or bring in any recent lab work.**

2. **Please write down on separate piece of paper everything you eat/drink for 3 days; include time of day**