Nutrition Analysis Intake Form

Please complete the information below so I can better understand your needs and know how to contact you. Thank you. PLEASE PRINT.

Your privacy is very important to me. All papers are kept in a locked file cabinet when not in use. Computer information is fingerprint-protected. Discarded documents with personal information are cross-shredded. No one but you, except as required by law, has a right to see any of your information without your expressed, written permission. E-mail is considered written permission.
Please initial that you have read this statement. _____________
Today's Date: ___________________

Name: ____ **Male/Female**

City/State/Country:____
____

E-mail: _______________________________________

Height: ____________ **Weight** __________**lbs Age**___________

Emergency contact (name and phone): ____

To whom may I thank for referring you to me? ______________________________________

Please tell me the primary concern that brings you here? __________________________
____

What are 3 other health concerns, if any, in order of importance?
1. ____
2. ____
3. ____

What other treatments have you sought/are you seeking to address these concerns? (Brief explanation. We will talk more about this)
____
____

Are you in any pain? What kind and where? _____________________________________
____

Hospitalizations/Significant Surgeries _______________________________________
____
____

What do you feel is good about your health? ____________________________________
____
____

What is your vision of the level of health you want to achieve ultimately?
____
____

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What kind of physical activity do you enjoy (walking, gardening, yoga, etc.) and how often?
____
____

What do you do for a job? How do you perceive your job? (Love it, enjoyable, stimulating, stressful, tolerate it, hate it, exposed to toxins, etc.) If you don't have a job, what fills your day?____
____

Please rate your overall stress level: 1=Low, 10=unbearable ___________________________
What do you do to alleviate stress? ____
____

How many hours of sleep do you usually get? ___________________________
Do you have trouble falling asleep? ____________
Do you have trouble staying asleep? ________ **If yes, what wakes you?** __________________

How do you usually feel when you wake up? Exhausted Tired Ready to Face Day Anxious Energetic Hungry Not hungry Other ____________

Please list ALL medications you take at least 1 time per week (over-the-counter and/or prescription) and ALL supplements you take, their frequency and their use: *(please attach additional paper, if needed)*

OTC or Rx Meds You Take	Frequency	Reason Taking It

Supplements You Take	Frequency	Reason Taking It

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Please circle the number which corresponds to the level of your symptoms:
0=never or hardly ever; 1=sometimes, mild; 2=often, moderate; 3=almost always, severe)

Category 1 Hypo				
Undigested food in stool	0	1	2	3
Excessive burping	0	1	2	3
Extended fullness after eating	0	1	2	3
Bloating	0	1	2	3
Poor appetite	0	1	2	3
Easily-upset stomach	0	1	2	3
Regular constipation	0	1	2	3
Aware of food allergies	0	1	2	3
Offensive breath	0	1	2	3
Heartburn/acid reflux	0	1	2	3

Category 2, SI,P				
Abdominal cramps	0	1	2	3
Indigestion 1-3 hours later	0	1	2	3
Fatigue after eating	0	1	2	3
Abdominal gas	0	1	2	3
Diarrhea	0	1	2	3
Alternating diarrhea/constipation	0	1	2	3
Constipation with increased fiber	0	1	2	3
Mushy stools	0	1	2	3
Pellet stools	0	1	2	3
Mucus in stools	0	1	2	3
Stools that float	0	1	2	3
3 or more large BM per day	0	1	2	3
Undigested food in stool	0	1	2	3
Foul-smelling stool	0	1	2	3
Pain in left side under ribs	0	1	2	3
Chronic stomach pain	0	1	2	3
Nausea	0	1	2	3
Acid reflux/heartburn	0	1	2	3
Alcoholism, diabetes, osteoporosis	0	1	2	3
Acne	0	1	2	3
Known food allergies	0	1	2	3
Wheat/barley/rye/oats sensitivity	0	1	2	3
Difficulty gaining weight	0	1	2	3
Dry, flaky skin	0	1	2	3
Dry, brittle hair	0	1	2	3
Gallstones/gallbladder disease	0	1	2	3

Category 3, GR				
Sour taste in mouth, esp. in morning	0	1	2	3
Regurgitate undigested food mouth	0	1	2	3
Burning sensation from citrus after swallowing	0	1	2	3
Frequent nighttime coughing	0	1	2	3
Heartburn	0	1	2	3
Excessive burping	0	1	2	3
Difficulty swallowing foods/drinks	0	1	2	3

Category 4, L,G				
Greasy/fatty foods cause distress	0	1	2	3
Headaches following eating	0	1	2	3
Light colored/whitish stools at times	0	1	2	3
Foul-smelling stool	0	1	2	3
BM less than once daily	0	1	2	3
Hard stool	0	1	2	3
Sour/bitter taste in mouth esp. in am	0	1	2	3
Grey-colored skin	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellow in whites of eyes/skin	0	1	2	3
Personal history of jaundice/hepatitis	0	1	2	3
High total cholesterol >200	0	1	2	3
Triglyceride level >115	0	1	2	3
Low HDL cholesterol	0	1	2	3
Offensive breath	0	1	2	3
Body odor	0	1	2	3
Fatigue/sleepiness after eating	0	1	2	3
Pain in right side under ribs	0	1	2	3
Painful to pass stool	0	1	2	3
Retained water	0	1	2	3
Big toe pain	0	1	2	3
Pain radiating along outside of leg	0	1	2	3
Dry skin/hair	0	1	2	3
Red blood in stool	0	1	2	3
Gallbladder removed	0	1	2	3
Frequent use of acetaminophen	0	1	2	3

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Category 5, LkG, D, P				
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucus or blood in stool	0	1	2	3
Arthritis, joint pain or swelling	0	1	2	3
Chronic/frequent fatigue	0	1	2	3
Food allergy/sensitivity/intolerances	0	1	2	3
Sinus/nasal congestion	0	1	2	3
Chronic/frequent inflammations	0	1	2	3
Eczema/skin rashes/hives	0	1	2	3
Asthma/hay fever/airborne allergies	0	1	2	3
Mental: poor memory, confusion	0	1	2	3
Emotional: mood swings	0	1	2	3
Use of NSAIDs (aspirin, ibuprofen)	0	1	2	3
Antibiotic use: multiple times	0	1	2	3
Alcohol consumption	0	1	2	3
Raw meat/raw fish eater	0	1	2	3
Colitis/Crohn's disease/Celiac disease	0	1	2	3
Headaches/migraine headaches	0	1	2	3

Category 6, LI, C				
Diarrhea: recurring/seasonal	0	1	2	3
Alternating constipation/diarrhea	0	1	2	3
Constipation	0	1	2	3
Colds: frequent and recurrent	0	1	2	3
Bladder/kidney/vaginal infections	0	1	2	3
Frequent laxative use	0	1	2	3
Abdominal cramps relieved by passing gas or stools	0	1	2	3
Nail fungus: toe/fingernail	0	1	2	3
Antibiotic use: multiple times	0	1	2	3
Meat eater	0	1	2	3
Rapidly failing vision	0	1	2	3
Recurrent stomach pain	0	1	2	3
Blood or pus in stool	0	1	2	3
IBS (irritable bowel syndrome)	0	1	2	3
Feeling that bowels do not empty completely	0	1	2	3
Hard dry or small stool	0	1	2	3
Coated or "fuzzy" tongue	0	1	2	3
Large amounts of foul-smelling gas	0	1	2	3

Category 7, Y				
Fatigue or lethargy	0	1	2	3
Worn out, drained	0	1	2	3
Poor memory	0	1	2	3
Feeling spacey or forgetful	0	1	2	3
Indecisiveness	0	1	2	3
Insomnia	0	1	2	3
Numbness, burning or tingling	0	1	2	3
Muscle aches/weakness	0	1	2	3
Pain and/or swelling in joints	0	1	2	3
Abdominal pain	0	1	2	3
Constipation	0	1	2	3
Diarrhea	0	1	2	3
Bloating, belching or intestinal gas	0	1	2	3
Vaginal itching, burning, discharge	0	1	2	3
Burning on urination	0	1	2	3
Prostatitis	0	1	2	3
Impotence	0	1	2	3
Endometriosis or infertility	0	1	2	3
PMS	0	1	2	3
Painful cramps or heavy flow	0	1	2	3
Emotional anxiety/upset	0	1	2	3
Cold hands/feet or chilliness	0	1	2	3
Shaking or irritable when hungry	0	1	2	3
Headaches	0	1	2	3
Psoriasis	0	1	2	3
Chronic rashes or itching	0	1	2	3
Food sensitivity or intolerance	0	1	2	3
Reaction to perfumes, cleaning products, insecticides, etc.	0	1	2	3
Bothered by tobacco smoke/chemicals	0	1	2	3
Antibiotic use: multiple times	0	1	2	3
Crave sugar, breads alcohol	0	1	2	3
Whitish "fuzzy" covering on tongue	0	1	2	3
Number of pregnancies, if applicable	0	1	2	3
Oral contraceptives use, # of years	0	1	2	3
Steroid drug usage (prednisone, asthma inhalers, nasal sprays, etc.)	0	1	2	3
Fungal infections: athlete's foot, ringworm, tinea versacolor, jock itch, nail fungus, etc.	0	1	2	3

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Category 8, Hyper				
Hungry again 1 hour after eating	0	1	2	3
Chronic abdominal pain	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Chronic antacid (Tums, etc.) use	0	1	2	3
Stomach pains before/just after eating	0	1	2	3
Butterfly sensations in stomach	0	1	2	3
Burping/bloating	0	1	2	3
Stomach pain when worried, angry, upset, etc.	0	1	2	3
Sudden, acute indigestion	0	1	2	3
Relief from symptoms by drinking milk, cream or carbonated beverages	0	1	2	3
Past ulcer				
Current ulcer	0	1	2	3
Black stool without taking iron supplements	0	1	2	3
Previous/current use of pain medicine: aspirin, ibuprofen, etc.	0	1	2	3

Category 9, BSF				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on caffeine to keep going or get started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category 10, IR				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is = or > hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category 11, EC				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hrs of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category 12, AF				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category 13, DT				
Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

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Category 14, IT				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Males Only – Prostate				
Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside legs or heels	0	1	2	3
Feeling incomplete bowel evacuation	0	1	2	3
Restless legs at night	0	1	2	3

Males Only – Male Hormones				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness/weakness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat around chest & hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in past	0	1	2	3

Menstruating Females Only – Female Hormones				
Are you perimenopausal?	Y	N		
Different menstrual cycle lengths	Y	N		
Extended menstrual cycle> 32 days	Y	N		
Shortened menses < 24 days	Y	N		
Pain/cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain/swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable/depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3
Increased sex drive	0	1	2	3
Diminished sex drive	0	1	2	3

Menopausal Women Only:				
How many years have you been?				
Uterine bleeding/Spotting	Y	N		
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	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Vaginal pain, dryness or itching	0	1	2	3

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Health History: Condition	You	Mother	Father	Sibling	Grandparents
Allergies: Seasonal and/or Epi-pen					----------------
Asthma					----------------
Attention-Deficient Disorder/ ADHD/Learning Disability		---------	---------	---------	-----------------
Bladder Problems (Incontinence, UTIs)		---------	---------	---------	----------------
Blood Disorders/Anemia/Leukemia					
Blood Sugar Problems: Diagnosed Diabetes (Type 1 or Type II?)					
Blood Sugar Problems: Hypoglycemia, Insulin Resistance, Metabolic Syndrome					
Bone problems (Osteoporosis, etc.)					
Bowel Problems (including IBS, Crohn's, Colitis, Other)					
Cancer (type?)					
Chronic Fatigue Syndrome					----------------
Circulation Problems/ Angina/Intermittent Claudication					
Cold Sores/HSV/HPV (Herpes viruses)		---------	---------	---------	---------------
Fibromyalgia					
Gallbladder problems				---------	---------------
Glaucoma					---------------
Gluten Intolerance/Celiac Disease					
Gout					
Heart Damage: Rheumatic fever, etc.		---------	---------	---------	--------------
Heart Disease/Attack/Stroke					
High Blood Pressure					---------------
Immune System Disorders					
Joint problems: Osteoarthritis					
Joint Problems: Rheumatoid Arthritis					
Kidney problems/Water Retention					--------------
Liver Problems (Jaundice, Elevated Enzymes, etc.)					---------------
Low Blood Pressure					----------------
Lung/Respiratory Condition					
Menstrual Irregularities			---------		----------------
Mental Health Issues (Depression, Bipolar, Anxiety, Panic Attacks, Obsessive-Compulsive, Schizophrenia)					
Migraines					
Multiple Sclerosis					
Muscle Cramps/Spasms		---------	---------	---------	----------------
Neurological Problems (Epilepsy, Parkinson's, Alzheimer's, etc.)					

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Health History: Condition	You	Mother	Father	Sibling	Grandparents
Obesity					----------------
Periodontal disease/Gum/mouth/teeth problems (What about significant other?)					---------------- ----------------
Polio		---------	---------	---------	----------------
Skin Problems (Acne, Eczema, Psoriasis, Rashes, etc.)					----------------
Stomach Problems (Ulcers, GERD, etc.)					----------------
Thyroid Problems (Hypo, Hashimoto's, Hyper, Graves)					---------------- --------------
Vision Problems (Retina, Macula, Cataracts, etc.)					
Significant Diseases/Problems not listed					

If you answered "yes" to having allergies, what are they, when do you get symptoms and how bothersome are they? ____

____

____

Do you smoke? How much? ____________
How often do you drink alcohol? ______________ **Caffeine?** ____________________
Do you have or have you ever had eating disorders? Type? _______________________

____

How is your appetite? ____
Vegetarian? What type? ______________________________________ **Vegan? Y/N**
How much weight have you gained or lost in the last 6 months? _____________________
Do you like to cook? ____
Do you cook for yourself? Y/N For others? Whom? ___________________________
Do you plan meals? How often? ____
Do you feel like you have to cater to certain likes/dislikes? ______________________
Is there anything you will not eat? ______________________________________
Does anyone cook for you? Whom? When? _________________________________

____

Do you have control over when, with whom and where you eat? _____________________

____

____

____

Where do you routinely eat: (restaurant w/ co-workers, eat at desk, eat bites as you can, regular family meals, eat in front of TV, read while eating, etc?)
Breakfasts: ____
Lunches: ____
Dinners: ____

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Snacks: ____

Which, if any, diets have you tried before? ____________________________
____

What did you like/dislike about the diets? ____________________________
____
____

What specifically would you like, or do you think you need, to be changed in your diet? _____
____
____
____

Do you read labels? What, if anything, are you interested in learning about nutrition?
____
____
____

For possible Bioimpedance Analysis Testing: **Please answer these important questions.**
Are you or do you suspect you might be pregnant? ______________________
Do you have an implantable electronic device? ______________________
Do you have a diagnosed heart condition? ______________________

******Please attach copies of any blood/saliva/urine/stool-test results, and also attach any genetic reports if you want me to include those !******

Thank you for thoughtfully taking the time to answer the questions. In order to help you to the best of my ability, I will carefully read your responses written here and read your Diet Diary pages and any other information provided. I will then like to meet with you to discuss any areas in which I may need further clarification, to ensure that I correctly understand and address your needs and concerns, and to establish baseline nutrient-status markers before I make any detailed recommendations.

Please alert me to any supplements and any blood/saliva/urine/stool/genetic- test results from tests that you recently receive between now and your appointment. Thanks!