Name ____ Address ____

Phone _______________________ email __________________________________ cell phone #___________________________________

I understand that these questions and counseling are to help me to research nutritional support for my health care, and are not in any way intended to take the place of medical care. I understand that I must report any changes in my health, and health care, to update my records as the changes occur. I understand that I must also inform those involved about any food restriction or nutrient restrictions that my medications or doctors state that I must follow.

____
Signature / date

If Female answer the following:

Are you trying to become pregnant? Yes____ No____ I understand that is of great importance that I let those, who are in charge of my nutritional support, know when I am trying to conceive, so that my nutritional support will not interfere with the health of the baby.

____
Signature / date

Height _______ Weight_______ Age ______ Married__ Single__

1) Briefly describe your condition and those areas that you feel you need support in?

____

____

____

____

____

2) What are your symptoms?

____

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____

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3) What medications are you taking? Please include what each medication is used for? [this includes non-prescription medicines, but not supplements]

____

____

____

____

____

4) Have you ever had any surgery? What was the surgery for, and when (approximately)?

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5) Has any of your medical examinations consisted of specific tests, and what were the results?

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6) What is your family's history of health problems? List the condition and what relation this person is, or was, to you.

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7) What doctors or specialists are you seeing now, or in the last 3 years? Specify if now, or in the past, and approximately how long ago since you have been released from their care.

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8) Describe a typical day's diet. We know this is not always the same, but give a good general idea of what you eat as your first meal and what time, and so on.

1st meal ________________________________ what time__________________________

____

____

____

2nd meal ________________________________ what time__________________________

____

____

____

3rd meal ________________________________ what time__________________________

____

____

____

Snacks _________________________________ what time or times__________________

____

____

____

9) What are your bowel elimination habits? [please check all those that apply]

Once a day_____ Once every____ days More than once a day & how many times______________

Is stool color? light___ dark___ very dark______ Is stool? Soft____ very loose___ hard___ liquid___
Is stool volume: normal long round ________ or small round individual ________ or tiny in width _________

10) What are your urination habits? Normal____ Frequent_____

Are you awaking at night with a full bladder? ____

Do you have any problems holding your bladder before you can get relief?_________________________

11) What are your drinking of fluid habits? How many ounces of fluid do you drink daily and what type? Please specify what type of water [tap, spring, steam distilled, carbonated, flavored, etc.]

Ounces______ Type________ Ounces______ Type________

Ounces______ Type________ Ounces______ Type________

12) Do you drink alcohol? Ounces______ Type________ How often_________

Do you smoke? packs per day_____ How many years______

13) What about your sleep habits? How many hours?_____

What time do you try to go to bed?_____ What time do you get up?______ Do you wake up at night?_____

How many times do you wake up in the night and about what time or times?___________________________

____

Do you use any sleep aids (pills (what kind?), noise machine or fan, ear plugs, sleep mask, etc), if so, what?

____

14) What are your exercise habits? What type of exercise do you do?_______________________________

____

How often, and for how long do you do this exercise?____

How long have you been doing this?____

15) What is your occupation?

____

What kind of physical, or non-physical activity does this job [or if do not work, what does your daily activity]

consist of?____

____

____

16) Do you or others describe you as a person who: [please check all those that apply]

Worries a lot_______ is Stressed______ or Nervous____

Anger easily______ Hard time focusing_______ Hyper or nervous energy_______

or energetic in a normal way______

17) Do you get weak or shaky when you do not eat?______________

How often do you feel you need to eat to prevent this? 3 meals a day______ or more and how many ___

____

18) How is your vision?________________________

19) How is the health of your teeth and gums?_________________

20) How is your hearing?______________

21) How is your memory? Do you periodically forget what you are doing___________ or can't remember important things, like appointments, promises made to friends, to take medicines, etc?___________________________

22) When you eat food do you experience? [please check all those that apply]

fullness for awhile after you eat_______ fullness for a long time after you eat_______

or feel full all the time_________

23) Do you experience after you eat: [please check all those that apply]

gas____ bloating______ belching______ heartburn______

24) How is the condition of your nails? [please check all those that apply]

brittle_____ cracked_____ ridges_____ healthy_____

grow fast_______ grow slow_______

If use of artificial nails caused poor nail health please indicate here ________

25) How is the condition of your hair? [please check all those that apply]

brittle_______ dry_____ oily______ dandruff______ healthy______ grow fast_______ grow slow_______

Are you balding? In front___ In back___ If all over where did your balding begin? front______ back______

26) What is the condition of your skin? [please check all those that apply]

Normal______ dry______ oily______ acne_______

Is the acne? all the time_______ or just during stress_____ or menstrual cycle______

27) Do you have problems with loss of taste or smell? taste_______ smell______

How long have you noticed this (approximately)?___________________________

28) Do you have any allergies food or airborne (dust, pollen, mold, etc)? Please specify what allergen and what test was done to verify that allergy.

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____

29) What supplements are you taking now?

____

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____

____

____

____

29) Have you discontinued any supplements within the last year and why?

____

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____

30) This question is for females only: Do you have regular menstrual cycles?_____________ If you are no longer menstruating, did you have regular menstrual cycles?______________ When was the date [approximately] of your last menstrual cycle?_____________
Is your menstrual flow light____ medium_____ or heavy______
Does it last: 2 to 3 days________ 4-7 days _______ 7days and longer_________
Are you periods painful, if yes describe the pain:

____

____

____

If you have children, how many, and did you have a hard time conceiving?_______________________

Did you have difficulties during your pregnancy(s)? ____

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Program recommendations: [to be filled out during session]

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Program recommendations: [to be filled out during session]