NUTRITION CLIENT INTAKE FORM

PERSONAL INFORMATION

Name: _____ DOB: __/__/____ Sex: ____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone (H): _____ Phone (C): _____ E-mail: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Are you new to the practice? □ No □ Yes (how did you hear about us?): _____

HEALTH HISTORY

What would you like help with at this time?

_____

_____

What health concerns/medical conditions, if any, have you experienced in the past 10 years?

Concern or condition:	When did this develop?	Any treatment received:

Any surgeries/hospitalizations? □ No □ Yes: _____

Do you have any known allergies? □ No □ Yes: _____

Any major chemical exposure? □ No □ Yes: _____

Are you part of a recovery program? □ No □ Yes: _____

Have you traveled outside of the US? □ No □ Yes: _____

For women, are you currently pregnant □ No □ Yes, due date: _____

Breast feeding □ No □ Yes or trying to conceive? □ No □ Yes

FAMILY HISTORY

Please fill in the table below to the best of your knowledge.

Relationship	Alive/Deceased	Present Health/Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brother(s)		
Sister(s)		
Children		

MEDICATIONS AND SUPPLEMENTS

Please list all prescription medications and nutritional supplements (dietary or herbal) you are currently taking. Use a separate sheet, if needed.

Name	Dosage	Frequency	Length of time	Purpose

Please list any medications or supplements you have used in the past for a considerable amount of time? _____

PHYSICAL ACTIVITY & LIFESTYLE

Activity	Type	# Times/Week	Duration
Stretching/Yoga			
Strength Training			
Aerobic/Cardio			
Other			

Are there issues or limitations that inhibit your physical activity? □ No □ Yes

How many hours of sleep do you get a night/day? _____ Average bed time: _____

Current Occupation: _____ How long? _____ Hours/Week: _____

Relationship Status: _____ Who do you share your home with? _____

On a scale from 1-10, with 1 being low and 10 being high, how stressful is your:

Work: _____ Current health status: _____ Social/family situation: _____ Life in general: _____

NUTRITION, ANTHROPOMETRICS, & SYMPTOMS

In one or two words, how would you describe your relationship with food? _____

Favorite foods: _____ Cravings? _____

How many times per week do you eat the following meals at home versus out?

Breakfast: _____ Lunch: _____ Dinner: _____

For the meals not eaten at home, where are you eating? _____

Approximately how many ounces of water do you drink per day? _____

Height: _____ Current Weight: _____ Goal Weight (if applicable): _____

Bowel movements/day: _____ Consistency: _____ Urinations/day: _____ Color: _____

NUTRITION CLIENT INTAKE FORM

Please check all that apply:

Section 1 (LHCl):

□ Indigestion, bloating or sleepy after meals
□ Heartburn or acid reflux symptoms
□ Tendency to allergies, eczema or asthma
□ Nausea in evenings
□ Difficulty digesting protein/complex meals
□ Loss of taste for meat
□ Sense of excessive fullness after meals
□ Low appetite, feel like skipping breakfast
□ Undigested food in stool
□ Anemia, unresponsive to iron

Section 2 (HHCl):

□ Heartburn or acid reflux symptoms
□ Nausea in mornings
□ Strong appetite, excessive salivation
□ Aggravated by spicy or sour foods
□ Sour or foul smelling burps

Section 3 (LVGB):

□ Pain between shoulder blades
□ Stomach upset by fried or fatty foods
□ Loose stools with fatty foods
□ Shiny, floating, or smelly stools
□ Nausea
□ Light, clay-colored or green/yellow stools
□ Dry skin year-round
□ Itchy feet or skin peels on feet
□ Gallbladder attacks
□ Gallbladder removed
□ Bitter taste in mouth, especially after meals
□ Easily intoxicated or hungover
□ Pain under right side of rib cage
□ Hemorrhoids
□ Varicose veins
□ Sensitive to chemicals (perfume, diesel fumes, tobacco smoke, cleaning agents, etc.)

Section 4 (SI):

□ Food allergies or sensitivities
□ Frequent intake of allergenic foods
□ Strong attachment to allergenic foods
□ Craving or binging of allergenic foods
□ Abdominal bloating 1-2 hours after eating
□ Pulse speeds up after eating
□ Crohn's disease
□ Frequent sinus infections or migraines
□ Suffer from asthma
□ Airborne allergies
□ Experience hives

Section 5 (IM):

□ Catch colds at beginning of winter
□ Frequent colds, flu or infections
□ Experience mucous producing cough
□ Never get sick
□ History of chronic viral infection
□ Food allergies and/or sensitivities

Section 6 (LI):

□ Coating on your tongue
□ Anus itches
□ Frequent fungal or yeast infections
□ Yeast symptoms increase with sugar/alcohol
□ Less than one bowel movement per day
□ Constipation, stools difficult to pass
□ Excessive foul-smelling gas
□ Irritable bowel or mucous colitis
□ Bad breath or strong body odor
□ Cramping in lower abdomen
□ History of parasites
□ Stools have corners or edges
□ Stools are flat or ribbon-shaped

Section 7 (BS/IS):

□ Eat <5 servings of fruits and vegetables/day
□ Crave sweets, bread, pizza, pasta or chips
□ Crave coffee or sugar in afternoon
□ Sleepy in afternoon
□ Fatigue is relieved by eating
□ Binging or uncontrolled eating
□ Excessive appetite
□ Sweets give boost of energy, then crash
□ Headache, irritability when meals are skipped
□ Heart palpitations after eating sweets
□ Frequent thirst
□ Frequent urination
□ Uncontrolled eating of sweets and carbs
□ Tend to gain weight in the belly
□ Have pre-diabetes or diabetes (or family history)
□ Have PCOS or hypoglycemia (or family history)
□ Alcoholism (or family history)
□ Elevated triglycerides or cholesterol
□ High blood pressure

Section 8 (ASR):

□ High or low blood pressure
□ Have a low libido
□ Have difficulty falling asleep
□ Get <8 hours of sleep per night
□ Go to bed frequently after midnight
□ Get less than 1 hour of sunlight per day
□ Work the night shift
□ Emotional eater
□ Feel anxious or have panic attacks
□ Frequent shallow breathing
□ Experience heart palpitations
□ Cravings for salt or sweets
□ Experience chronic or prolonged fatigue
□ Can't get started in the morning without coffee

Section 9 (THY):

□ Feel cold when everyone else is warm
□ Have course or brittle hair
□ Experience constipation
□ Have thinning hair or hair loss
□ Experience a loss of sex drive
□ Missing outer 1/3 of eyebrows
□ Experience depression and/or anxiety
□ Trouble losing weight
□ Low blood pressure or heart rate
□ Elevated cholesterol
□ Have a hoarse voice
□ Dry, scaly skin
□ Cold hands and feet
□ Experience fatigue
□ Experience fluid retention

Section 10 (CV):

□ Irregular or heavy breathing
□ Experience discomfort at high altitudes
□ Sigh frequently or "air hunger"
□ Shortness of breath with moderate exertion
□ Experience swelling of ankles
□ Blush or face turns red for no reason
□ Experience dull pain or tightness in chest
□ Have muscle cramps upon exertion

FOOD FREQUENCY QUESTIONNAIRE

How often do you consume the following items on a daily, weekly, or monthly basis? Place an "x" in the appropriate box and leave items you don't eat or drink blank.

Food/Drink	Monthly	Weekly	Daily	2+ x/day	What forms?
Caffeine					
Soda (diet or regular)					
Alcohol					
Herbal tea					
Red meat (beef)					
White meat (poultry, pork)					
Eggs					
Fish/shellfish					
Nuts & seeds					
Fruits					
Vegetables					
Lentils & beans					
Oils & fats					
Dairy					
Soy					
Whole grains					
Grain-based products					
Junk, fast, or fried foods					
Frozen dinners					
Artificial sweeteners					
Chewing gum or candy					

THREE-DAY FOOD DIARY

Please write down all food and drink over a 72-hour period, including water. Record information as soon as possible after meals. Consume what you would normally eat or drink – the purpose is to analyze current eating habits. Be as detailed as possible (milk – what kind? chicken – fried, baked, or breaded?). Record the amount of food consumed using standard measurements, such as 8 ounces, ½ cup, 1 teaspoon, etc.

Day 1:	Day 2:	Day 3:
Breakfast:	Breakfast:	Breakfast:
Snack:	Snack:	Snack:
Lunch:	Lunch:	Lunch:
Snack:	Snack:	Snack:
Dinner:	Dinner:	Dinner:
Snack:	Snack:	Snack: