Discover Health Chiropractic Center
Nutrition Form

Name: _____ Date: _____

Date of birth: _____ Age: _____

Gender: o Female o Male

Primary address: _____

Primary Phone: _____ Secondary phone: _____

Email address: _____

Best way to contact you? _____

Primary Physician: _____ Clinic: _____

Address: _____ Phone: _____

Other Provider: _____ Clinic: _____

Address: _____ Phone: _____

- Referred by: _____

Biometrics & Lab Results *(Leave blank if there are no recent results)*

Biometric/Lab	**Result**	**Date**
Height		
Weight		
Blood Glucose		
Hemoglobin A l c		
Total Cholesterol		
LDL Cholesterol		
HDL Cholesterol		
Triglycerides		
Blood Pressure		
TSH		

Medications & Supplements

Please list all medications, nutritional supplements, and herbs/botanicals (use separate sheet if needed)

Medication Name	**Dose**	**Frequency**	**Reason**

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Supplement Name	Dose	Frequency	Reason

Surgeries & Hospitalizations

Please list any previous injuries, surgeries, and hospitalizations (provide date & your age, if known)

_____

_____

_____

Family History

Please note any family history of the following: heart disease, cancer, stroke, high blood pressure, overweight, lung disease, kidney disease, mental health or addiction

Family Member: _____ Health Condition: _____

Family Member: _____ Health Condition: _____

Family Member: _____ Health Condition: _____

Family Member: _____ Health Condition: _____

Personal Medical History relevant to Nutritional Health (please circle all that apply)

Gastro-intestinal	Respiratory/Pulmonary	Hematology/Blood	Hepatic/Pancreatic	Renal
Celiac disease	Asthma	Anemia: Type	Cirrhosis	Chronic Kidney disease
Crohn's disease	Bronchitis	Bleeding disorder	Gallbladder disease	Dialysis
Diverticular disease	Chronic Sinusitis	Thalassemia	Hepatitis	Kidney failure
Gastric reflex disease	Emphysema		Pancreatitis	Kidney stones
Irritable Bowel	Pneumonia			Nephritis
Lactose intolerance	Sleep apnea			

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Ulcerative Colitis	Tuberculosis			

Please circle all that apply

Urinary	**Cardiovascular**	**Metabolic/Endocrine**	**Inflammatory/Autoimmune**	**Musculo-skeletal**
Incontinence	Angina/chest pain	Metabolic syndrome	Chronic Fatigue	Osteopenia
Urinary Tract Infections	Cardiovascular disease	Pre-diabetes	Fibromyalgia	Osteoporosis
	Heart valve disease	Diabetes: Type	Gout	Osteoarthritis
	High blood pressure	Hypoglycemia	Lupus SLE	
	High cholesterol	Polycystic ovary disease	Rheumatoid Arthritis	
	Peripheral artery disease	Infertility		
	Stroke	Thyroid disease		

Please circle all that apply

Neurological	**Eating Disorder**	**Dermatological**	**For Females**	**Cancer**
Addiction	Anorexia	Acne	Currently pregnant	Type:_____
ADD/ADHD	Binge eating	Eczema	Irregular/ No periods	Type: _____
Anxiety	Bulimia	Rosacea	Gestational diabetes	Type: _____
Autism	Compulsive overeating	Skin rashes	Peri-menopausal	
Depression	Other:		Post-menopausal	
Headaches				
Migraines				
Multiple Sclerosis				
Parkinson's Disease				
Seizures				
Sleep difficulties				

Allergies

Foods	**Medications**	**Environmental**

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Nutrition History

Have you made any changes in your eating habits because of your health? Yes or No

Please describe: _____

Do you currently follow a special diet or nutritional program? Yes or No

Please describe: _____

Do you avoid any particular foods? Yes or No

Please describe: _____

Have you had any recent history of weight loss or weight gain? Yes or No

Please describe: _____

Do you have any adverse food reactions (allergies or intolerances?) Yes or No

Please describe: _____

Current Meal Preparation and Eating Habits

Who purchases food for your home?

Where do you purchase food? _____

Who prepares meals at home? _____

How many meals per day do you eat? _____ How many snacks? _____

How many meals do you eat out per week? _____

Do you drink alcohol? Yes or No if so, how many: _____

Do you drink coffee or other caffeinated beverages? Yes or No if so, how many: _____

Do you use any natural or artificial sweeteners? Yes or No if so, how many: _____

Do you feel it is important to eat organic and free range? Yes or No

Current Eating Habits

Please circle all the factors that apply to your current eating habits

Love to eat	Poor snack habits	Struggle with eating issues
Love to cook	Do no plan meals	Eat because I have to
Fast eater	Time constraints	Negative relationship with food
Erratic eating patterns	Travel frequently	Dislike healthy food

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Family members have different tastes	Emotional eater	Confused about food/nutrition
Rely on convenience	Eat too much/overeat	Live or often eats alone

Please note any additional comments about your lifestyle/ eating habits:

_____

_____

_____

_____

Physical Movement

Do you engage in moderate cardiovascular physical activity for a minimum of 20 minutes at least 3 days a week? (For example: brisk walking, jogging, hiking, cardio exercise classes, cycling?) Yes or No

Activity	**Type/ Intensity**	**# Days per Week**	**Duration (minutes)**
Stretching/Yoga			
Cardio/ Aerobics			
Strength Training			
Sports or Leisure			

Please note any problems that limit your physical activity:

_____

_____

Social/Personal History

Marital Status: _____

Children: _____

How many live in your household? _____

Stress Management

Daily stressors: Rate on a scale of 1 (low) to 10 (high)

Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____

Excess stress in your life? Yes or No

Do you easily handle stress? Yes or No

How do you handle stress? _____

Do you believe stress is presently reducing the quality of your life? Yes or No

Sleep

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Average number of hours you sleep per night during the week? _____

Average number of hours you sleep per night on the weekends? _____

Trouble falling asleep? Yes or No

Rested upon waking? Yes or No

Do you wake up during the night? Yes or No if so, how many times? _____

How would you rate the overall quality of sleep? 1 __ 2__ 3__ 4__ 5__ (*1 is the lowest/5 is the highest)*

Smoking

Do you smoke? Yes or No if yes, how many years? _____ Packs per day? _____

Secondhand Smoke? Yes or No if yes, how many years? _____

Readiness Assessment

In order to improve your own health, how willing are you to: Rate on a scale of 5 (very willing) to 1 (not willing)

Please circle number

Significantly modify your diet	5 4 3 2 1
Take nutritional supplements each day	5 4 3 2 1
Keep record of everything you eat each day	5 4 3 2 1
Modify your lifestyle (work demands, sleep habits, exercise)	5 4 3 2 1
Practice a relaxation or mindfulness technique	5 4 3 2 1
Engage in regular exercise/ physical activity	5 4 3 2 1

Personal Goals

What do you hope to achieve in your nutrition consult? _____

_____

If you alleviate three problems, what would they be? *List your three main health/nutrition concerns:*

1.
2.
3.

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel better? _____

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Patient Signature: _____ Date: _____

Nutrition Consent Form

• According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

□ A vitamin is not a drug, NEITHER is a mineral, trace element, amino acid, herb, or homeopathic remedy.

□ Although, a vitamin, a mineral, a trace element, amino acid, herb, or homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

□ Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy; for any disease or particular bodily symptom.

□ Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition; supporting the physiological and bio-mechanical processes of the human body.

□ Nutritional advice and nutritional intake may also enhance the stabilization of the eight: (8) chemical components of the VSC (Vertebral Subluxation Complex).

□ I have read and understand the above:

Signature: _____ Date: _____