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** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  |  |  |
| 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** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**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 |
| 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 not any problems that limit your physical activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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**

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:*

When was the last time you felt well? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did something trigger your change in health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes you feel better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_