*Please fill out this entire form to the best of your ability. If you do not know the answer to something, leave it blank. If you have any questions about how to answer something, ask during our meeting. This form is not being used to diagnose any medical condition or to prescribe a controlled substance. The purpose of this form is not to indicate a medical opinion, but is for educational purposes only.*

|  |  |
| --- | --- |
| **Date** | Click here to enter a date. |
| **First and Last Name** | Click here to enter text. |
| **Cultural Heritage** | Click here to enter text. |
| **Street address, City, State, Zip Code** | Click here to enter text. |
| **Email Address** | Click here to enter text. |
| **Phone** | Click here to enter text. |
| **Occupation** | Click here to enter text. |
| **Emergency Contact/Phone** | Click here to enter text. |
| **Referred by** | Click here to enter text. |

**Please list info for all Medical Providers you are working with or whom you have active prescriptions for (if there are more than 10, please attach list of additional):**

Medical Provider #1

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #2

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #3

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #4

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #5

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #6

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #7

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #8

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #9

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #10

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

**What is the reason for your visit?** Click here to enter text.

**List your top 5 health concerns in order of importance:**

1. Click here to enter text.

2. Click here to enter text.

3. Click here to enter text.

4. Click here to enter text.

5. Click here to enter text.

**How would you describe your health?** Click here to enter text.

**Briefly state your relationship to the following, including any issues, concerns and/or successes:**

Eating: Click here to enter text.

Sleeping: Click here to enter text.

Social Life: Click here to enter text.

Creative Projects/Hobbies: Click here to enter text.

Exercise/Activity: Click here to enter text.

Spiritual Practices: Click here to enter text.

Family: Click here to enter text.

Career: Click here to enter text.

Cooking: Click here to enter text.

**Do you cook?** Yes No If no, who does? Click here to enter text.

**Do you grocery shop?** Yes No If no, who does? Click here to enter text.

**Do you read food labels?** Yes No If yes, what do you look for? Click here to enter text.

**Do you currently follow a special diet or nutritional program?** Yes No If yes, check all that apply:

Low Fat Low Carb High Protein Low Sodium Diabetic/Low sugars

Vegetarian Vegan Pesca-vegetarian Paleo/Primal Renal

Candida Weight Loss Macrobiotic Raw Gluten Free

Other: Click here to enter text.

**Do you have any food allergies/intolerances/Sensitivites?** Yes No If yes, list foods: Click here to enter text.

Any foods cause indigestion symptoms? Yes No If yes, list foods: Click here to enter text.

Any foods you avoid? Yes No List foods and why you avoid them: Click here to enter text.

**Which foods, if any, do you feel you can’t live without?** Click here to enter text.

**How many alcohol containing beverages do you generally consume per week?** Click here to enter text.

**How many glasses of these do you generally consume daily?**

CoffeeChoose an item. Regular Soda Choose an item. Diet Soda Choose an item.

Fruit juice Choose an item. Water Choose an item. Black tea Choose an item.

Green Tea Choose an item. Herbal tea Choose an item. Energy Drinks Choose an item.

**Any immediate relatives diagnosed with Ulcerative Colitis, Crohn’s Disease, Celiac Disease, IBS, IBD?** Yes No

If yes, who? Click here to enter text.

**Height (feet and inches):**  Click here to enter text.

**If known, current weight** Click here to enter text. Desired weight, if different Click here to enter text.

How often do you weight yourself? Choose an item.

**Rate your stress level for each of these during the average week on scale of 0-10 with 0 being none and 10 being overwhelming:**

Work Choose an item. Family Choose an item. Social Choose an item.

Financial Choose an item. Health Choose an item. Other: Click here to enter text.: Choose an item.

Is stress reducing the quality of your life? Yes No

Do you have a stress relief technique? Yes No If yes, how do you relieve stress? Click here to enter text.

**Do you like the work you do?** Yes No

What are your passions in life? (e.g. If you could be doing anything right now and be paid for it, in your idealistic world what would that be?) Click here to enter text.

**Do you have trouble falling asleep?** Yes No

Do you have problems with insomnia? Yes No

Average hrs of sleep--workdays? Click here to enter text. Average sleep hrs on days off? Click here to enter text.

**Check all factors that apply to your current lifestyle and eating habits:**

Fast eater  Slow eater Late night eater Eat while working

Eat in front of tv/computer Dislike “healthy” food Family dislikes “healthy” food

Time constraints Love to eat Travel frequently Plans meals/menus

Rely on “convenience” items You have special dietary needs/preferences

Your family has special dietary needs/preferences Eat more than 50% of meals away from home

You only eat because you have to Eat when bored Eat when sad, lonely or depressed

Eat when stressed Don’t eat when stressed Don’t like to cook

Love to cook Eat in the middle of the night Confused about nutrition advice

Crave sweets Have afternoon sugar cravings Choose “unhealthy” snacks

Have you ever smoked/chewed tobacco? Yes No For how long? Click here to enter text.

Do you currently smoke/chew tobacco? Yes No Amount per day Click here to enter text.

**List all medications, prescription and over the counter that you currently take: (if there are more than 15 please attach list of any additional)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose** | **Frequency** | **Start Date (mo/yr)** | **Reason for Use** |
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**List all supplements, vitamins, herbs, etc. that you currently take: (if there are more than 15 please attach list of any additional)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Supplement & Brand** | **Dose** | **Frequency** | **Start Date (mo/yr)** | **Reason for Use** |
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Have any of your medications or supplements ever caused you any unusual side effects or problems? Yes No

If yes, which ones and what was the side effect? Click here to enter text.

Have you ever used NSAIDs—Non-steroidal anti-Inflammatory Drugs (e.g. Advil, Aleve, Motrin, Aspirin, Ibuprofen, etc.) on a regular basis? Yes No

Generally, how many NSAIDs pills do you take a week? Choose an item.

How many times per week, generally, do you currently take Acid Blocking Drugs (e.g. Tagamet, Zantac, Prilosec, Tums, etc.)? Choose an item.

Have you used steroids (prednisone, nsasal allergy inhalers, etc.) in the the past? Yes No

If yes, when? Click here to enter text. How much? Click here to enter text. How long? Click here to enter text.

Have you taken antibiotics more than 3x/in the last year? Yes No

Have you taken any long-term antibiotics? Yes No If yes, when? Click here to enter text.

For how long? Click here to enter text.

**List hospitalizations, include dental surgeries and serious injuries/broken bones (add additional sheet if necessary):**

|  |  |
| --- | --- |
| **Date** | **Reason** |
| Click here to enter text. | Click here to enter text. |
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**Blood Type:**  A  B  O  AB  Rh negative  Don’t Know

**Check any conditions you currently have:**

Chicken Pox

Seasonal Allergies

Parasites/Giardia

Eating disorder

Hepatitis

Hypothyroidism

Hyperthyroidism

IBS/IBD

Heart disease

Anxiety

Asthma

Arthritis

Hiatal hernia

Gout

Frequent colds/flu

Crohn’s disease

High blood pressure

Headaches

Migraines

Tuberculosis

Urinary Tract Infections

Eczema

Kidney Infection

Kidney stones

Macular degeneration

Rapid weight loss

Rapid weight gain

Diabetes

Mental illness

Pneumonia

Interstitial cystitis

Psoriasis

Alcoholism

Drug addiction

Glaucoma

GERD

Hypoglycemia

Depression

Tonsillitis

Hemorrhoids

Gall stones

Candidiasis (yeast overgrowth)

Ulcer

Celiac disease

Chronic fatigue syndrome

Fibromyalgia

ADHD/ADD

Autoimmune conditions (please list): Click here to enter text.

Cancer (please list): Click here to enter text.

Dental problems:  Mercury amalgams  Toothache  Bleeding gums  Gum diease

**Check any conditions you have had previously that you no longer have:**

Chicken Pox

Seasonal Allergies

Parasites/Giardia

Eating disorder

Hepatitis

Hypothyroidism

Hyperthyroidism

IBS/IBD

Heart disease

Anxiety

Asthma

Arthritis

Hiatal hernia

Gout

Frequent colds/flu

Crohn’s disease

High blood pressure

Headaches

Migraines

Tuberculosis

Urinary Tract Infections

Eczema

Kidney Infection

Kidney stones

Macular degeneration

Rapid weight loss

Rapid weight gain

Diabetes

Mental illness

Pneumonia

Interstitial cystitis

Psoriasis

Alcoholism

Drug addiction

Glaucoma

GERD

Hypoglycemia

Depression

Tonsillitis

Hemorrhoids

Gall stones

Candidiasis (yeast overgrowth)

Ulcer

Celiac disease

Chronic fatigue syndrome

Fibromyalgia

ADHD/ADD

Autoimmune conditions (please list): Click here to enter text.

Cancer (please list): Click here to enter text.

**Birth History**

Term  Premature Any pregnancy/birth complications? Click here to enter text.

Breast fed, if yes how long? Click here to enter text.  Bottle fed

Did you eat a lot of candy or sugar as a child? Yes No

What were your favorite foods as a child? Click here to enter text.

**Women Only**

**Menstruation History**

Age at first period Click here to enter text.

Menses frequency (e.g. every 28 days): Click here to enter text. Length (e.g. 10 days): Click here to enter text.

Cramping Yes No

Clotting Yes No

Ever skipped your period? Yes No For how long? Click here to enter text.

**Check all that apply**

Fibrocystic breasts

Increased sex drive

Decreased sex drive

PMS

Endometriosis

Heavy periods

Facial hair growth

PCOS

Fibroids

Abnormal PAP

Infertility

Endometriosis

Have you ever used hormonal contraceptives (e.g. IUD, birth control pill, etc.): Yes No

When? Click here to enter text. For how long? Click here to enter text. Type? Click here to enter text.

Number of Pregnancies Click here to enter text. Number of living children Click here to enter text.

Date of last PAP Click here to enter text.

Result of last PAP Click here to enter text.

**Are you in menopause?**  Yes No Age at menopause Click here to enter text.

Check all that apply:

Hot flashes

Mood swings

Weight Gain

Incontinence

Concentration/memory problems

Vaginal dryness

Decreased libido

Depression

Use of hormone therapy Yes No For how long? Click here to enter text.

Date of last Mammogram/result? Click here to enter text.

**Is there anything else I should know?** Click here to enter text.