Nutrition Patient Intake Form

Last name_____
First name_____
Date of Birth_____
Address_____
_____
Phone number_____
Marital Status_____
Sex M F
Are you currently being treated in this office? For what? By whom?
_____
_____
How did you hear about us?_____

Past Medical and Surgical History:
Please indicate when you have had these conditions and the treatments provided

Anemia
Arthritis
Asthma
Bronchitis
Cancer
Chronic Fatigue Syndrome
Crohn's Disease or Ulcerative Colitis
Diabetes
Emphysema
Epilepsy, convulsions, or seizures
Gallstones
Gout
Heart attack/Angina
Heart failure
Hepatitis
High blood fats (cholesterol, triglycerides)
High blood pressure (hypertension)
Irritable bowel
Kidney stones
Mononucleosis
Pneumonia
Rheumatic fever
Sinusitis
Sleep apnea
Stroke
Thyroid disease
Other (describe)

Surgical Procedures
Appendectomy
Dental Surgery
Gall Bladder
Hernia
Hysterectomy
Tonsillectomy
Other (describe)

Social History

Do you currently smoke? Yes No
Have you ever smoked? Yes No
If yes, for how long and how many packs/day?
_____
Are you exposed to second hand smoke? Yes No
Do you consume alcohol? Yes No
How often?_____
How many drinks per sitting?_____

Family History
Please indicate who had these conditions and at what age

Arthritis
Cancer
Crohn's Disease/ Ulcerative Colitis
Diabetes
Gallstones
Heart Problems
High blood pressure
High cholesterol
Kidney problems
Stroke
Thyroid disease

Medications and Supplements

What medications are you taking now? Include non-prescription drugs.
Medication name, Date started, Dosage

1._____
2. _____
3. _____
4. _____
5._____
6. _____

Are you allergic to any medications? Yes No
If yes, please list medication and reaction:

_____
_____
_____

List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.
Vitamin/Mineral/Supplement name, Date started, Dosage

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Dietary Considerations

As a child, were there any foods that you had to avoid because they gave you symptoms?
Yes No
If yes, please: name the food and symptom (Example: milk – gas and diarrhea)

_____
_____
_____

How much/How often do you consume the following each week?
(Never, 1-3 times, 3-7 times, more than 7 times)

Candy _____
Cheese, Milk, Ice cream and other dairy products _____
Chocolate _____
Cups of coffee containing caffeine _____
Cups of decaf coffee or tea _____
Cups of tea containing caffeine _____
Diet soda _____
Regular soda _____
Salty foods _____
White bread products (rolls/bagels/pasta) _____
Sodas with caffeine _____
Sodas without caffeine _____

Are you on a special diet? Yes No

ovo-lacto vegetarian gluten free
diabetic vegan dairy free
dairy restricted other, please describe_____

Is there anything special about your diet that we should know? Yes No
If yes, please explain:

_____
_____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.?

Yes No

If yes, are these symptoms associated with any particular food or supplement(s)?

Yes No

Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

_____
_____
_____

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes No

Do you feel worse when you eat a lot of (circle if yes):

high fat foods
refined sugar (junk food)
high protein foods
fried foods
high carbohydrate foods
1 or 2 alcoholic drinks
other _____

Do you feel better when you eat a lot of (circle if yes):

high fat foods
refined sugar (junk food)
high protein foods
fried foods
high carbohydrate foods
1 or 2 alcoholic drinks

Does skipping a meal greatly affect your symptoms? Yes No

Have you ever had a food that you craved or really "binged" on over a period of time? Food craving may be an indicator that you may be allergic to that food. Yes No
If yes, what food(s)?

_____
_____
_____

Do you have an aversion to certain foods? Yes No
If yes, what foods?

_____

Do you exercise regularly? Yes No
If so, how many times a week
1x
2x
3x
4x or more
When you exercise, how long is each session?
<15 min
16-30 min
31-45 min
> 45 min

What type of exercise is it?

_____

Women only

Have you ever been pregnant? (If no, skip to question 53.) Yes No
Number of miscarriages _____ Number of abortions _____ Number of preemies _____
Number of term births _____ Birth weight of largest baby _____ Smallest baby _____
Did you develop toxemia (high blood pressure)? Yes No
Have you had other problems with pregnancy? Yes No
If so, please comment:

_____
_____
_____

Age at first period _____ Date of last Pap Smear _____
Date of last Mammogram_____
Pap Smear: Normal Abnormal
Mammogram: Normal Abnormal
Have you ever used birth control pills? Yes No If yes, when _____
Are you taking birth control pills now? Yes No
Are you in menopause? No Yes If yes, age at last period_____
How long have you been on hormone replacement therapy (if applicable)?

_____

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?
Yes No Not applicable

Recent Symptoms

Please circle if these symptoms occur presently or have occurred in the past 6 months.

GENERAL:
- Cold hands & feet
- Cold intolerance
- Daytime sleepiness
- Difficulty falling asleep
- Early waking
- Fatigue
- Fever
- Flushing
- Heat intolerance
- Night waking
- Nightmares
- No dream recall
- Unintentional weight loss
- Unintentional weight gain

HEAD, EYES & EARS:
- Conjunctivitis
- Distorted sense of smell
- Distorted taste
- Ear fullness
- Ear noises
- Ear pain
- Ear ringing/buzzing
- Eye crusting
- Eye pain
- Headache
- Hearing loss
- Hearing problems
- Lid margin redness
- Migraine
- Sensitivity to loud noises
- Vision problems

MUSCULOSKELETAL:
- Back muscle spasm
- Calf cramps
- Chest tightness
- Foot cramps
- Joint deformity
- Joint pain
- Joint redness
- Joint stiffness
- Muscle pain
- Muscle spasms
- Muscle stiffness
- Muscle twitches:
  - Around eyes
  - Arms or legs
- Muscle weakness
- Neck muscle spasm
- Tendonitis
- Tension headache
- TMJ problems

MOOD/NERVES:
- Anxiety
- Auditory hallucinations
- Black-out
- Depression
- Difficulty:
  - Concentrating
  - With balance
  - With thinking
  - With judgment
  - With speech
  - With memory
- Dizziness (spinning)
- Fainting
- Fearfulness
- Irritability
- Light-headedness
- Numbness
- Other Phobias
- Panic attacks
- Paranoia
- Seizures
- Suicidal thoughts
- Tingling
- Tremor/trembling
- Visual hallucinations

EATING:
- Binge eating
- Bulimia
- Can't gain weight
- Can't lose weight
- Carbohydrate craving
- Carbohydrate intolerance
- Poor appetite
- Salt craving

DIGESTION:
- Anal spasms
- Bad teeth
- Bleeding gums
- Bloating of:
  - Lower abdomen
  - Whole abdomen
- Blood in stools
- Burping
- Canker sores
- Cold sores
- Constipation
- Cracking at corner of lips
- Dentures w/poor chewing
- Diarrhea
- Difficulty swallowing
- Dry mouth
- Fissures
- Gas
- Heartburn
- Hemorrhoids
- Intolerance to:
  - Lactose
  - All milk products
  - Gluten (wheat)
  - Corn
  - Eggs
  - Fatty foods
  - Yeast
- Liver disease/jaundice (yellow eyes or skin)
- Lower abdominal pain
- Mucus in stools
- Nausea
- Periodontal disease
- Reflux
- Sore tongue
- Strong stool odor
- Undigested food in stools
- Upper abdominal pain
- Vomiting

SKIN PROBLEMS:
- Acne on back
- Acne on chest
- Acne on face
- Acne on shoulders
- Athlete's foot
- Bumps on back of upper arms
- Cellulite
- Dark circles under eyes
- Ears get red
- Easy bruising
- Eczema
- Herpes - genital
- Hives
- Jock itch
- Lackluster skin
- Moles w color/size change

Oily skin
Pale skin
Patchy dullness
Psoriasis
Rash
Red face
Sensitive to bites
Sensitive to poison ivy/oak
Shingles
Skin cancer
Skin darkening
Strong body odor
Thick calluses
Vitiligo

SKIN, ITCHING:
Anus
Arms
Ear canals
Eyes
Feet
Hands
Legs
Nipples
Nose
Penis
Roof of mouth
Scalp
Skin in general
Throat
Eyes
Feet
- cracking
- peeling

Hair
- dry
- oily
- coarse
- brittle
- unmanageable
- thinning/loss

Hands
- cracking
- peeling

Mouth/throat
Scalp
- dandruff

Skin in general

LYMPH NODES:
Enlarged/neck
Tender/neck
Other enlarged/tender

NAILS:
Brittle
Curve up
Frayed
Fungus - fingers
Fungus - toes
Pitting
Ragged cuticles
Ridges
Soft
Thickening of:
- Finger nails
- Toenails

White spots/lines

RESPIRATORY:
Allergies (seasonal)
Bad breath
Bad odor in nose
Cough - dry
Cough - productive
Hay fever : Spring
- Summer
- Fall
- Change of season

Hoarseness
Nasal stuffiness
Nose bleeds
Post nasal drip
Sinus fullness
Sinus infection
Snoring
Sore throat
Wheezing
Winter stuffiness

CARDIOVASCULAR:
Angina/chest pain
Breathlessness
Heart attack
Heart murmur
High blood pressure
Irregular pulse
Mitral valve prolapse
Palpitations
Phlebitis
Swollen ankles/feet
Varicose veins

URINARY:
Bed wetting
Hesitancy
Infection
Kidney disease
Kidney stone
Leaking/incontinence
Pain/burning
Prostate enlargement
Prostate infection
Urgency

MALE REPRODUCTIVE:
Discharge from penis
Ejaculation problem
Genital pain
Impotence
Infection
Lumps in testicles
Poor libido (sex drive)

FEMALE REPRODUCTIVE:
Breast cysts
Breast lumps
Breast tenderness
Ovarian cyst
Poor libido (sex drive)
Endometriosis
Fibroids
Infertility
Vaginal discharge
Vaginal odor
Vaginal itch
Vaginal pain

Premenstrual:
- Bloating
- Breast tenderness
- Carbohydrate craving
- Chocolate craving
- Constipation
- Decreased sleep
- Diarrhea
- Fatigue
- Increased sleep
- Irritability

Menstrual:
- Cramps
- Heavy periods
- Irregular periods
- No periods
- Scanty periods
- Spotting between periods

Goals

What goals would you like to achieve being treated in this office?

_____
_____
_____
_____
_____What, if any, limitations do you have with working with the doctors in our office toward achieving these goals?

_____
_____
_____

Thank you for providing this information so that the doctor may provide you with the best possible care.