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Integrative Nutrition Form

All of your answers will be confidential, unless you personally request release of your information.

Name _____

Address _____

Email Address _____

Phone #s Work_____Home_____Cell_____

How do you prefer to be contacted? _____

Date of Birth _____

HEALTH CONCERNS
Describe your primary health concern:

_____

_____

Have you been given a medical diagnosis for this problem? If so, what?

_____

_____

When did it start? Can you identify a cause or instigating factor?

_____

_____

To what extent does this problem interfere with your daily activities?

_____

Are you currently receiving any treatment for this condition? Please describe:

_____

_____

Have you had this or similar conditions in the past?

_____

What help have you sought out for these problems before?

_____

_____

What kinds of therapies have you tried?

_____

_____

At what point in your life did you feel best?

_____

Any serious illnesses/hospitalizations/injuries?

_____

_____

Are you pregnant, trying to get pregnant or breastfeeding?_____

Are you menopausal? _____

YOUR MEDICAL HISTORY

□ Cancer

□ Diabetes

□ Pain, stiffness or swelling

□ Arthritis

□ Muscle or joint pain/Inflammation

□ Muscle cramping

□ Fatigue

□ Depression, struggle with regulating mood/anxiety

□ Irritability

□ Difficulty concentrating

□ Compulsive eating/binge eating/strict dieting

□ Constipation

□ Diarrhea

□ GI bloating, gas, abdominal pain or discomfort

□ Nausea or vomiting

□ Digestive Problems

□ Acid reflux/GERD

□ Irritable Bowel Syndrome (IBS)

□ Gallbladder disease

□ Unwanted weight gain

□ Unwanted weight loss

□ Difficulty Losing Weight

□ Eating disorder

□ Difficulty chewing or swallowing

□ Difficulty digesting foods

□ Undigested stool

□ Dental or gum problems

□ Poor appetite

□ Allergies or food sensitivities

□ ADD/ADHD

□ Poor concentration

□ Memory issues

□ Migraines

□ Difficulty sleeping on insomnia

□ Heart disease

□ Irregular heart beat

□ Kidney disease

□ High blood pressure

□ Stroke

□ Environmental allergies

□ Peri-menopause or menopausal symptoms

□ Osteopenia or osteoporosis

□ Bleed or bruise easily

□ Asthma

□ Respiratory problems

□ Immunity problems - getting sick often

□ Recurrent sore throats/colds/sinus infections

□ Thyroid problem

□ Adrenal problem

□ Hepatitis

□ Blood clotting disorder

□ Bacterial or yeast overgrowth

□ Vaginal infections including Candida/ yeast infections

□ Urinary infections

□ Skin problems/acne/hives

□ Unusual loss of hair/thinning

□ Concussion

□ Faintness or dizziness

□ Kidney stones

□ Frequent urination

□ Water retention

□ Eye – such as macular degeneration or glaucoma

□ Clotting issues (slow or excessive)

□ Chronic ear infections

□ Hearing loss

□ Gut dysbiosis

□ Dental or gum problems

□ Neurological problems/seizures

How is/was the health of your father?

_____

How is/was the health of your mother?

_____

List medical problems of immediate family members related to the above.

_____

_____

_____

Have you had any significant surgeries?

_____

Any history of alcohol or drug addiction?

_____

MEDICINES/SUPPLEMENTS

Current Medications (names and dosages)

_____

_____

_____

_____

_____

_____

Current Vitamins, Supplements/Herbs

_____

_____

_____

_____

_____

In the past were you on any medication for a length of time?

_____

_____

Have you been treated often with antibiotics? Please explain.

_____

Are you allergic to any medications or supplements? What is your reaction?

Med/Supplement *Reaction* _____

_____

_____

_____

_____

_____

LIFESTYLE

Do you have a regular exercise program? Please describe type, duration, frequency.

_____

_____

Do you have any physical conditions that limit your ability/safety to exercise?

_____

Cigarette smoker? # of packs/day

_____

Alcohol per week? Average amount week_____

Average amount of coffee, tea, cola, or high caffeine "energy" drinks per week

_____

Stress – rate your stress level on a scale of 1-10 (highest) for an average week:

_____

Do you have allergies to anything in the environment? If so, what is your reaction?

(Please indicate if your allergies are worse during a particular season or time of year.)

Substance (e.g. perfume, mold, mites, bug bites) *Reaction* _____

_____

_____

_____

_____

_____

Relationship status ____ If married, spouse's name/occupation _____

Children (names and ages) _____

Are family and friends aware of your desire to make food and/or lifestyle changes? If so, are they supportive?

_____

How often do you socialize? ____How do you like to spend social time? _____

_____

Do you have hobbies? _____

Do you have pets? If so, what kinds?_____

Occupation? _____Hrs/week

Volunteer work or family caretaking? _____Hrs/week

Sleep – do you sleep well? _____Avg hrs/night _____

Do you feel rested when you wake up? _____

Do you have trouble falling asleep? _____Do you wake up at night/why? _____

Do you participate in any exercise/active sports (not TV)? If so, which ones and how often?

_____

_____

DIET

Currently, are you on a special diet?

_____

_____

Any dietary restrictions (vegan/vegetarian/celiac)?

_____

_____

Any food allergies or intolerances? What is your reaction?

Food _____ *Reaction* _____

_____

_____

_____

_____

_____

Have you tried particular diets?

_____

_____

What kind of foods did you eat often as a child?

Breakfast _____

Lunch_____

Dinner_____

Snacks_____

Liquids_____

Do you crave sugar, salt, coffee, cigarettes, or other things?

_____

Do you have any favorite foods?

_____

Are there certain foods that you avoid?

_____

Are there certain foods trigger eating for you?

_____

What percentage of your food is home cooked vs. store or restaurant cooked?

Home cooked _____ Supermarket cooked_____Restaurant/takeout_____

Do you cook? ____Do you enjoy cooking?____Are you "open" to doing more home cooking?_____

Do you do the grocery shopping? _____

Where do you shop? _____

Do you try to shop for organic or unprocessed foods?

_____

Do you usually eat with family and/or friends?

_____

Circle relevant descriptions about your meals:

rushed relaxed seated at table standing/walking around in car in front of TV

Height____ Weight_____ Has your weight changed lately?

Would you like your weight to be different? If so, what would you like your weight to be?

_____

"The most important thing I should change about my diet to improve my health is:

_____

_____"

Anything else you want to share?

_____

_____

_____

Coordinating Physician

_____

Address and Phone

_____