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Today's Date:_____

**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(s)? If so, what?

_____

_____

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

_____

_____

What makes you feel better? _____What makes your feel worse? _____

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

_____

Are you currently receiving any treatment for this condition(s)? 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 or perimenopausal? _____Any related symptoms? _____

_____

**YOUR MEDICAL HISTORY**

□ Cancer

□ Autoimmune disease

□ Pain, stiffness or swelling

□ Arthritis, joint pain, inflammation

□ Muscle pain

□ Muscle cramping

□ Chronic pain

□ Fatigue

□ Chronic fatigue syndrome

□ Fibromyalgia

□ Back pain

□ Depression

□ Anxiety

□ Mood swings

□ Irritability

□ Difficulty concentrating

□ Constipation

□ Diarrhea

□ Undigested stool

□ Difficulty chewing or swallowing

□ Dental or gum problems

□ Difficulty digesting foods

□ Food allergies, sensitivities

□ GI bloating, gas

□ Abdominal pain, discomfort

□ Nausea or vomiting

□ Acid reflux, GERD

□ Hiatal hernia

□ Irritable bowel syndrome (IBS)

□ Crohn's disease, ulcerative colitis

□ Celiac disease

□ Gallbladder disease, gallstones

□ Gut dysbiosis

□ SIBO, bacterial, yeast overgrowth

□ Diabetes

□ Unwanted weight gain

□ Unwanted weight loss

□ Difficulty losing weight

□ Eating disorder

□ Compulsive eating/binge eating

□ Strict dieting

□ Poor appetite

□ Concussion

□ Dizziness

□ Neurological problems/seizures

□ ADD/ADHD

□ Poor concentration

□ Memory issues

□ Migraines

□ Difficulty sleeping or insomnia

□ Heart disease

□ High blood fats (cholesterol,triglycerides)

□ Irregular heart rate

□ Water retention

□ High blood pressure

□ Stroke

□ Hepatitis

□ Fatty liver

□ Kidney disease

□ Kidney stones

□ Urinary infections

□ Prostate condition

□ Frequent urination

□ Urination during night

□ Multiple chemical sensitivities

□ Environmental allergies

□ Anemia

□ Bleed or bruise easily

□ Clotting issues (slow or excessive)

□ Asthma

□ Respiratory problems

□ Immunity problems, getting sick often

□ Recurrent sore throats,colds,sinus infections

□Recurrent cold sores

□ Skin problems, rash,itchiness, eczema

□ Acne

□ Frequent hives

□ Unusual loss of hair/thinning

□ Vaginal infections

□Peri-menopause or menopausal symptoms

□PMS

□PCOS

□ Osteopenia or osteoporosis

□ Hyperthyroid

□ Hypothyroid

□ Adrenal problem

□ Lyme disease

□ COVID-19

□ Gout

□ Eye concern - macular degeneration,glaucoma, dry eye

□Chronic ear infections

□ Hearing loss

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

_____

_____

_____

Have you had any significant surgeries or injuries?

_____

Any history of alcohol or drug addiction?

_____

**MEDICATIONS**

Current Prescribed and OTC Medications (names and dosages and purpose)

_____

_____

_____

_____

_____

_____

_____

_____

_____

**VITAMINS AND SUPPLEMENTS**

Current Vitamins, Supplements/Herbs (names, dosages and purpose)

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

Have you been treated often with antibiotics? Please explain.

_____

_____

In the past or currently were you on any prolonged use of:

NSAIDS (like Advil, Aleve, Motrin, Aspirin)?_____

Tylenol? _____

Acid blocking drugs like PPIs?_____

BIrth control pills? _____

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?

_____

Do you regularly spend time outdoors?_____

Cigarette smoker? # of packs/day _____ 2nd hand smoke? _____

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:_____

Any recent major life changes? _____

Have you extensively traveled or lived outside the US? _____

Have you knowingly lived in or worked in a building with mold or water damage? _____

_____

Do you have allergies or sensitivities 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?

_____

_____

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?_____

What is your weight range?_____

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

_____