Janet Zarowitz, MS, RD, CDN
Janet@mysupplementRD.com
914-222-3919

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 (Use mouse to check box left of each condition if it applies)

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, eczema, itchiness

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: (Check box to right of option if applies)

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