

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? Yes No

Have you made any changes in your eating habits because of your health? Yes No Describe: _____

Do you currently follow a special diet or nutritional program? Yes No

Check all that apply:

- Low Fat Low Carbohydrate High Protein Low Sodium Diabetic No Dairy No Wheat
 Gluten Restricted Vegetarian Vegan Ultrametabolism
 Specific Program for Weight Loss/Maintenance Type: _____ Other _____

Height (feet/inches) _____

Current Weight _____

Usual Weight Range +/- 5 lbs _____

Desired Weight Range +/- 5 lbs _____

Highest adult weight _____

Lowest adult weight _____

Weight Fluctuations (> 10 lbs.) Yes No

Body Fat % _____

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Have you ever had your metabolism (resting metabolic rate) checked? Yes No If yes, what was it? _____

Do you avoid any particular foods? Yes No If yes, types and reason _____

If you could only eat a few foods a week, what would they be? _____

Do you grocery shop? Yes No If no, who does the shopping? _____

Do you read food labels? Yes No _____

Do you cook? Yes No If no, who does the cooking? _____

How many meals do you eat out per week? 0-1 1-3 3-5 >5 meals per week

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

- | | |
|---|---|
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Significant other or family members have special dietary needs or food preferences |
| <input type="checkbox"/> Erratic eating pattern | <input type="checkbox"/> Love to eat |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Eat because I have to |
| <input type="checkbox"/> Late night eating | <input type="checkbox"/> Have a negative relationship to food |
| <input type="checkbox"/> Dislike healthy food | <input type="checkbox"/> Struggle with eating issues |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Emotional eater (eat when sad, lonely, depressed, bored) |
| <input type="checkbox"/> Eat more than 50% meals away from home | <input type="checkbox"/> Eat too much under stress |
| <input type="checkbox"/> Travel frequently | <input type="checkbox"/> Eat too little under stress |
| <input type="checkbox"/> Non-availability of healthy foods | <input type="checkbox"/> Don't care to cook |
| <input type="checkbox"/> Do not plan meals or menus | <input type="checkbox"/> Eating in the middle of the night |
| <input type="checkbox"/> Reliance on convenience items | <input type="checkbox"/> Confused about nutrition advice |
| <input type="checkbox"/> Poor snack choices | |
| <input type="checkbox"/> Significant other or family members don't like healthy foods | |

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

SMOKING

Currently Smoking? Yes No How many years? _____ Packs per day: _____

Attempts to quit: _____

Previous Smoking: How many years? _____ Packs per day? _____

Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits

None 1-3 4-6 7-10 > 10 If "None," skip to Other Substances

Previous alcohol intake? Yes (Mild Moderate High) None

Have you ever been told you should cut down your alcohol intake? Yes No

Do you get annoyed when people ask you about your drinking? Yes No

Do you ever feel guilty about your alcohol consumption? Yes No

Do you ever take an eye-opener? Yes No

Do you notice a tolerance to alcohol (can you "hold" more than others)? Yes No

Have you ever been unable to remember what you did during a drinking episode? Yes No

Do you get into arguments or physical fights when you have been drinking? Yes No

Have you ever been arrested or hospitalized because of drinking? Yes No

Have you ever thought about getting help to control or stop your drinking? Yes No

OTHER SUBSTANCES

Caffeine Intake: Yes No | Coffee cups/day: 1 2-4 > 4 | Tea cups/day: 1 2-4 > 4

Caffeinated Sodas or Diet Sodas Intake: Yes No

12-ounce can/bottle 1 2-4 > 4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.): _____

Are you currently using any recreational drugs? Yes No Type _____

Have you ever used IV or inhaled recreational drugs? Yes No

EXERCISE

Current Exercise Program: (List type of activity, number of sessions/week, and duration)

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotomics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? Low Medium High

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? Yes No

If yes, please describe: _____

Do you usually sweat when exercising? Yes No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? Yes No
Are you happy? Yes No
Do you feel your life has meaning and purpose? Yes No
Do you believe stress is presently reducing the quality of your life? Yes No
Do you like the work you do? Yes No
Have you ever experienced major losses in your life? Yes No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? Yes No
Would you describe your experience as a child in your family as happy and secure? Yes No

STRESS/COPING

Have you ever sought counseling? Yes No
Are you currently in therapy? Yes No Describe: _____
Do you feel you have an excessive amount of stress in your life? Yes No
Do you feel you can easily handle the stress in your life? Yes No
Daily Stressors: Rate on scale of 1-10
Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____
Do you practice meditation or relaxation techniques? Yes No How often? _____
Check all that apply: Yoga Meditation Imagery Breathing Tai Chi Prayer Other: _____
Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes No

SLEEP/REST

Average number of hours you sleep per night: >10 8-10 6-8 < 6
Do you have trouble falling asleep? Yes No
Do you feel rested upon awakening? Yes No
Do you have problems with insomnia? Yes No
Do you snore? Yes No
Do you use sleeping aids? Yes No Explain: _____

ROLES/RELATIONSHIP

Marital status Single Married Divorced Gay/Lesbian Long Term Partnership Widow

List Children:

Child's Name	Age	Gender

Who is Living in Household? Number: _____ Names: _____

Resources for emotional support?

Check all that apply: Spouse Family Friends Religious/Spiritual Pets Other: _____

What is your source of strength? _____

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At school				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? Yes No If yes, describe symptoms: _____

Do you have any food allergies or sensitivities? Yes List all: _____ No

Do you have an adverse reaction to caffeine? Yes No

When you drink caffeine do you feel: Irritable or Wired Aches & Pains

Do you adversely react to (Check all that apply):

- Monosodium glutamate (MSG) Aspartame (NutraSweet) Caffeine Bananas Garlic Onion
- Cheese Citrus Foods Chocolate Alcohol Red Wine
- Sulfite Containing Foods (wine, dried fruit, salad bars) Preservatives (ex. sodium benzoate)
- Other: _____

Which of these significantly affect you? Check all that apply:

- Cigarette Smoke Perfumes/Colognes Auto Exhaust Fumes Other: _____

In your work or home environment, are you exposed to: Chemicals Electromagnetic Radiation Mold

Have you ever turned yellow (jaundiced)? Yes No

Have you ever been told you have Gilbert's syndrome or a liver disorder? Yes No

Explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

- Herbicides Insecticides (frequent visits of exterminator) Pesticides Organic Solvents
- Heavy Metals Other: _____

Chemical Name, Date, Length of Exposure: _____

Do you dry clean your clothes frequently? Yes No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? Yes No

Do you have any pets or farm animals? Yes No

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

GENERAL

- Cold Hands & Feet
- Cold Intolerance
- Low Body Temperature
- Low Blood Pressure
- Daytime Sleepiness
- Difficulty Falling Asleep
- Early Waking
- Fatigue
- Fever
- Flushing
- Heat Intolerance
- Night Waking
- Nightmares
- No Dream Recall

HEAD, EYES & EARS

- Conjunctivitis
- Distorted Sense of Smell
- Distorted Taste
- Ear Fullness
- Ear Pain
- Ear Ringing/Buzzing
- Lid Margin Redness
- Eye Crusting
- Eye Pain
- Hearing Loss
- Hearing Problems
- Headache
- Migraine
- Sensitivity to Loud Noises
- Vision problems (other than glasses)
- Macular Degeneration
- Vitreous Detachment
- Retinal Detachment

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

- Agoraphobia
- 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
- Can't Maintain Healthy Weight
- Frequent Dieting
- Poor Appetite
- Salt Cravings
- Carbohydrate Craving (breads, pastas)
- Sweet Cravings (candy, cookies, cakes)
- Chocolate Cravings
- Caffeine Dependency

DIGESTION

- Anal Spasms
 - Bad Teeth
 - Bleeding Gums
 - Bloating of:
 - Lower Abdomen
 - Whole Abdomen
 - Bloating After Meals
 - Blood in Stools
 - Burping
 - Canker Sores
 - Cold Sores
 - Constipation
 - Cracking at Corner of Lips
 - Cramps
 - Dentures w/Poor Chewing
 - Diarrhea
 - Alternating Diarrhea and Constipation
 - Difficulty Swallowing
 - Dry Mouth
 - Excess Flatulence/Gas
 - Fissures
 - Foods "Repeat" (Reflux)
 - Gas
 - Heartburn
 - Hemorrhoids
 - Indigestion
 - Nausea
 - Upper Abdominal Pain
 - Vomiting
- Intolerance to:
- Lactose
 - All Dairy Products
 - Wheat
 - Gluten (Wheat, Rye, Barley)
 - Corn
 - Eggs
 - Fatty Foods
 - Yeast
- Liver Disease/Jaundice
(Yellow Eyes or Skin)
 - Abnormal Liver Function Tests
 - Lower Abdominal Pain
 - Mucus in Stools
 - Periodontal Disease
 - Sore Tongue
 - Strong Stool Odor
 - Undigested Food in Stools

