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medical center

NUTRITIONAL COUNSELING

Please fill out these forms to the best of your ability, including as much detail as you can. It will help in finding the root cause of any challenges.
Please type your responses or print clearly.

General Client Information

Today's date: _____ Your Age: _____

Full Name: _____

Birthdate: _____ Are you pregnant? _____

Mailing Address:

Phone Number: _____ E-mail: _____

Do you work? _____ If yes, please tell me about your position/what you do:

Do you enjoy your job? _____ Work Hours: _____ Days: _____

Current ***Medications*** you are taking and what they are for: (use back, if needed)

Current ***Supplements*** you are taking and what they are for: (use back, if needed)

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List the main reason(s) you are seeking Nutritional Counseling:

Do you have any known food allergies? _____

If yes, please list ***as much detail*** as you can about each allergy and how it affects you:
(use back, if needed)

Have you been hospitalized or in the E.R. in the last 12 months? _____

When was the last time you were on an antibiotic? _____

What were you on the antibiotic for? _____

Have you been diagnosed with diabetes? _____ If so, when? _____

Are you taking Insulin? _____

Do you have your gallbladder? _____ If no, when was removal? _____

Have you been diagnosed with any of the following: (If yes, what year/age)

_____ Gallstones _____ High Blood Pressure

_____ IBS _____ SIBO

_____ MTHFR _____ High Cholesterol

_____ Kidney Stones _____ PKU

_____ Stroke/Cardiac Event

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Please list any/all treatments and remedies you have received for any of the challenges marked above:

How often do you have a bowel movement?

❑ Once a day ❑ 2-3 times/day ❑ One a week ❑ Other:

_____

Diet and Eating Habits

Write down what your meals for the last ***THREE*** days:

Breakfast: _____

Lunch: _____

Dinner: _____

Are you a vegetarian? _____ Vegan? _____ If yes, how long? _____

Are you allergic to gluten (that you know of)? _____

How much water do you drink in a day? Please estimate in ***ounces***: _____

Most Recent Weight: _____ Height: _____ Goal Weight? _____

What is your main source of water: ***faucet, bottled, filtered, distilled?***

_____

Do you have a well for your water supply? _____

Do you notice certain food upset your stomach or cause you to have to use the restroom?

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Immune Function

Do you tend to catch colds easily? _____

Do you recover from illness slowly? _____

Have you been diagnosed with Lyme Disease, Epstein Barr, Candidiasis, or Herpes Simplex?

_____ If yes, which one? _____

Do you suffer from chronic *fatigue*, chronic *pain*, *fibromyalgia*, or *migraines*?

_____ If yes, when did it begin? _____

Do you have unexplained rashes, redness, or itching? _____

Do the insides of your ears itch? _____

Behavior

Do you believe you have a high stress lifestyle? _____

Do you worry a lot? _____

Do you experience mental fogginess or have trouble concentrating? _____

Do you wake up feeling unrested or depend on caffeine to get through the day?

_____

How many times a week do you eat out from fast food establishments or restaurants?

_____

How often do you:

- drink alcoholic beverages? _____
- smoke cigarettes or vape? _____

- If you quit, what was the date? How long did you smoke/vape before quitting?

  _____

- use antacids? _____
- use anti-inflammatory drugs/painkillers? (Advil, etc.) _____

What physical activities are you involved in throughout the year (include hiking, biking, walking)? How often do you partake in them?

What do you feel is your biggest obstacle in achieving wellness or living a healthy lifestyle?

Toxic Exposure

Do you have ***regular*** exposure to:

❑ exhaust fumes ❑ commercial chemicals ❑ tobacco smoke

❑ paint ❑ pesticides ❑ cleaning chemicals

Have you lived in a house or worked in an office with a history of water damage or known mold?

_____ If yes, when was your last exposure? _____

Do you have seasonal allergies? _____

If yes, please list the details of the allergy type and treatment:

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Think of your cabinet at home--name the top 3-5 cleaners you use to clean your home:

1.

2.

3.

4.

5.

Have you or do you suffer from any of the following? Mark all that apply. List how often/date of the last occurrence: (Mark all that apply)

❑ Hives _____ ❑ Trouble concentrating _____

❑ Nasal concession, regularly _____ ❑ Heartburn _____

❑ Edema _____ ❑ Watery eyes _____

❑ Headaches _____ ❑ Warm/red earlobes _____

❑ Insomnia _____ ❑ White spots on your fingernails _____

❑ Mood swings _____ ❑ Cracked, red tongue _____

Have you experienced any of the following in the last two (2) years? (mark all that apply)

❑ Death in the family ❑ Death of a close friend ❑ Animal attack

❑ Divorce in the family ❑ Car accident ❑ Other traumatic event:

_____

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Current and Past Diagnoses

Please take a moment to list any past or recent diagnoses you have had. (Such as Diabetes, Rheumatoid Arthritis, etc.)

Diagnosis	Date of Diagnosis	Treatment, if any

Please use the space below to list anything else you feel is important to note: