



Nutritional Intake Form

For your convenience please take the time to fully complete this form.

Name: _____ **Date:** _____

Date of Birth: (mm/dd/yy) _____ **Male** **Female**

Address: _____

Home Phone: _____ **Cell Phone:** _____

Email: _____ **Occupation:** _____

How did you hear about us? _____ **Preferred method for reminder calls:** Call Text Email
(Health Care Provider, Friend, Newspaper, Website, etc) (Please Circle One)

Family Doctor: _____ **Number:** _____

Emergency Contact:

Name: _____ **Relation:** _____

Home Phone Number: _____ **Work Phone Number:** _____

<p>Please list your main health goals and/or concerns:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p>Please list any major surgeries, illness or traumas from the past 5 years:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>
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Medication and Supplements: Please list all current medications, supplements, vitamins, minerals, herbs or homeopathic remedies, along with daily dosages, length of use, reasons for taking and any side effects you may be experiencing.

Medications	Dose/Day	How Long?	Reason for Medication	Side Effects
1.				
2.				
3.				
4.				

Supplements	Dose/Day	How Long?	Reason for Medication	Side Effects
1.				
2.				
3.				
4.				

In the last 5 years how many **courses of antibiotics** have you taken? _____

Your Medical History

Please indicate whether you have any allergies or sensitivities: _____
(Medicines, Environmental, Food, Other)

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals while at work, home or travelling?
If yes, please indicate what type and when this occurred: _____

How often do you have a bowel movement? _____

Please check all boxes below that apply to you:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Unexplained weight loss/gain | <input type="checkbox"/> Asthma/Bronchitis |
| <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Tonsils Removed | <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> Anxiety/Nervousness |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Bloating/Gas | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Crohn's or Colitis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Loss of Balance/Coordination | <input type="checkbox"/> Bladder Infections |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle Cramps/Spasms |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Poor Concentration |
| <input type="checkbox"/> Chronic Sore Throat | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Constipation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Candida/Leaky Gut | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Asthma/Bronchitis |

Female Clients

Are you currently trying to get pregnant? yes no

Are you pregnant? yes no If yes, how far along are you? _____

Are you pre-menopausal or menopausal? yes no

If yes, please list any symptoms your experiencing: _____

Current Dietary Habits

How many meals do you eat daily? _____ Snacks? _____

Please give examples of typical meals for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you experience symptoms after eating or if meals are missed? Please explain: _____

Please check any of the boxes below if you regularly eat, drink or use the following?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Margarine | <input type="checkbox"/> Fast Foods | <input type="checkbox"/> Fruit Juice | <input type="checkbox"/> Red Meat |
| <input type="checkbox"/> Candy | <input type="checkbox"/> Sweeteners such as Aspartame | <input type="checkbox"/> Milk | <input type="checkbox"/> Tap Water |
| <input type="checkbox"/> Fried Foods | <input type="checkbox"/> Beer | <input type="checkbox"/> Soft Drinks | <input type="checkbox"/> Filtered/Purified Water |
| <input type="checkbox"/> Processed Foods | <input type="checkbox"/> Wine | <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Baked Goods |
| <input type="checkbox"/> Luncheon Meats | <input type="checkbox"/> Spirits | <input type="checkbox"/> Recreational Drugs | <input type="checkbox"/> Coffee |

