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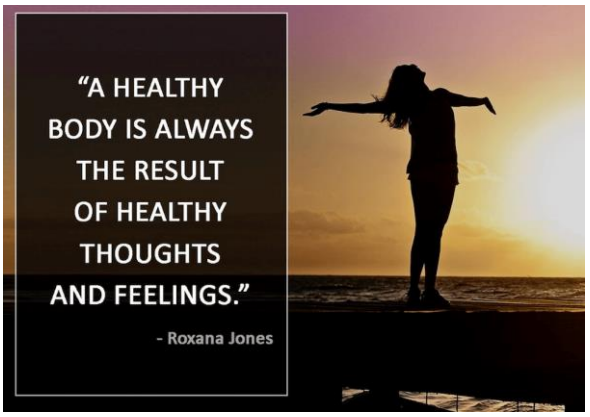

Intake For for Functional Nutrition Counseling

Thank you for taking the time to fill out this form and provide us with details of your health, goals and medical history. Feel free to save this form to your computer and type in your answers at your convenience. The boxes where you type your responses will expand to accommodate your text, so you will have as much space as you need.

Client Information:

Name_____Address_____City_____State_____Zip Code_____Phone(day)_____
_____
Phone(cell)_____
Email_____Referred by _____

Statistics:

Age_____Birth Date _____ Gender_____
_____Height _____Blood Type_____ Current Weight _____ Ideal Weight _____Weight One Year Ago _____

Birth Weight (if known) _____Birth Order (please list ages of biological siblings): _____
Family/Living Situation:
_____
_____Children:_____Occupation:_____
Exercise/Recreation:_____
_____History1. Have you lived or traveled outside of the United States? If so, when and where?:_____
2. Have you or your family recently experienced any major life changes? If so, please comment:
_____
_____
3. Have you experienced any major losses in life?_____ If so, please comment:_____ 4. How much time have you had to take off from work or school in the last year?
□0 to 2 days□3 to 14 days□more than 15 days

Health Concerns:

5.What are your main health concerns?_____
_____ (Describe in detail, including the severity of the symptoms):_____6. When did you first experience these concerns?_____
7.How have you dealt with these concerns in the past?□doctors□self-care
8.Have you experienced any success with these approaches? _____-
9.What other health practitioners are you currently seeing?_____
___ List name, specialty and phone # below._____
_____
_____
_____
_____ 10.Please list the date and description of any surgical procedures you have had (including breast reduction or augmentation).

_____
_____
_____
_____
_____

How often did you take antibiotics in infancy/childhood?_____ _____ 12 .How often have you taken antibiotics as a teen?_____ 13.How often have you taken antibiotics as an adult?_____ 14.List any medicine you are currently taking:_____
_____
_____
_____
_____
_____
_____ 15.List all vitamins, minerals, herbs and nutritional supplements you are now taking:_____
16.Have any other family members had similar problems (describe)?
_____
_____
_____
_____
_____
_____
_____

Nutritional Status:

17.Are there any foods that you avoid because of the way they make you feel?_____ If yes, please name the food and the symptom:_____
_____
_____ 18.Do you have symptoms immediately after eating like bloating, gas, sneezing or hives? If so, please explain:_____
_____

19.Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

_____

_____

_____20.Are there foods that you crave? If so, please explain:_____

_____

21.Describe your diet at the onset of your health concerns:_____

_____

_____

_____ 22.Do you have any known food allergies or sensitivities

_____

_____

_____

23.Which of the following foods do you consume regularly?☐soda ☐diet soda ☐refined sugar ☐alcohol ☐fast food ☐ gluten (wheat, rye, barley) ☐dairy (milk, cheese, yogurt) ☐coffee 24.Are you currently on a special diet? ☐ autoimmune paleo (AIP) ☐SCD/GAPS ☐dairy restricted or dairy-free ☐vegetarian ☐vegan ☐paleo ☐ blood type ☐raw☐ refined sugar-free ☐gluten-free ☐ Other (please describe)_____

_____

25.What percentage of your meals are home-cooked?☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 60 ☐ 70 ☐ 80 ☐ 90 ☐ 100

26.Is there anything else we should know about your current diet, history or relationship to food?_____

_____

_____

_____

Intestinal Status: 27.

Bowel Movement Frequency: ☐ 1–3 times per day ☐ more than 3 times per day ☐ not regularly every day

28.**Bowel Movement Consistency**□ soft & well formed □ often float □ difficult to pass □diarrhea □thin, long or narrow □small and hard □loose but not watery □alternating between hard and loose

29.**Bowel Movement Color:** □medium brown□very dark or black□greenish□blood is visible□variable□yellow, light brown□chalky colored□greasy, shiny 30.Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc: 31.Have you ever had food poisoning? If yes, please describe in detail, including 1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it:

_____

_____

_____

_____

When answering the following questions use the letter "N" for Now and the letter "P" for Past.

Medical Status:

32.Please identify any current or past conditions and add a date for when the condition appeared. In the space below each list, please briefly describe your symptoms, chosen treatment(s), and dates.

Gastrointestinal:

☐ _____Irritable Bowel Syndrome ☐ _____ Crohn's ☐ _____Ulcertative Colitis ☐ _____Gastritis or Peptic Ulcer Disease ☐ _____GERD (reflux or heartburn) ☐ _____Celiac Disease ☐ _____SIBO ☐ _____Gut infections ☐ _____Dysbiosis ☐ _____Leaky gut ☐ _____Food allergies, intolerances or reactions

☐ _____Gallstones ☐ _____Known absorption or assimilation issues

☐ _____Other Please briefly describe your symptoms, chosen treatment(s) and dates:

_____

_____

_____

Cardiovascular:

☐ _____Heart attack☐ _____Heart Disease ☐ _____Stroke

☐ _____Elevated cholesterol ☐ _____Arrhythmia (irregular heartbeat)

☐ _____Hypertension (high blood pressure) ☐ _____Rheumatic Fever

☐ _____Mitral Valve Prolapse ☐ _____Other Please briefly describe your symptoms, chosen treatment(s) and dates:

_____

_____

_____

Hormones/Metabolic:

☐ _____ Type 1 Diabetes ☐ _____ Type 2 Diabetes ☐ _____ Hypoglycemia ☐ _____ Metabolic Syndrome ☐ _____ Insulin Resistance or Pre-Diabetes ☐ _____ Hypothyroidism (low thyroid) ☐ _____ Hyperthyroidism (overactive thyroid) ☐ _____ Hashimoto's (autoimmune hypothyroid) ☐ _____ Grave's Disease (autoimmune hyperthyroid) ☐ _____ Endocrine problems ☐ _____ Polycystic Ovarian Syndrome (PCOS) ☐ _____ Infertility ☐ _____ Weight gain ☐ _____ Weight loss ☐ _____ Frequent weight fluctuations ☐ _____ Eating disorder ☐ _____ Menopause difficulties ☐ _____ Hair loss ☐ _____ Other Please briefly describe your symptoms, chosen treatment(s) and dates:_____

_____

_____

_____

Cancer:

☐ _____ Lung Cancer ☐ _____ Breast Cancer ☐ _____ Colon Cancer ☐ _____ Ovarian Cancer☐ _____ Prostate Cancer ☐ _____ Skin Cancer (Melanoma) ☐ _____ Skin Cancer (Squamous, Basal) ☐ _____ OtherPlease briefly describe your symptoms, chosen treatment(s) and dates:_____

_____

_____

_____

_____

Genital & Urinary Systems:

□ _____ Kidney Stones □ _____ Gout □ _____ Interstitial Cystitis □ _____ Frequent urinary tract infections□ □ _____ Erectile Dysfunction or Sexual Dysfunction □ _____ Frequent Yeast Infections□ _____ Other Please briefly describe your symptoms, chosen treatment(s) and dates:

_____
_____

Musculoskeletal/Pain

□ _____ Osteoarthritis □ _____ Fibromyalgia □ _____ Chronic Pain
□ _____ Sore muscles or joints, undiagnosed □ _____ Other Please briefly describe your symptoms, chosen treatment(s) and dates:_____
_____

Immune/Inflammatory:

□ _____ Chronic Fatigue Syndrome □ _____ Rheumatoid Arthritis
□ _____ Lupus SLE □ _____ Raynaud's □ _____ Psoriasis
□ _____ Mixed Connetive Tissue Disease (MCTD) □ _____ Poor immune function (frequent infections) □ _____ Food allergies □ _____ Environmental allergies □ _____ Multiple chemical sensitivities □ _____ Latex allergy
□ _____ Hepatitis □ _____ Lyme (and co-infections) □ _____ Chronic Infections (Epstein-Barr, Cytomegalo-virus, Herpes, etc.) □ _____ Other Please briefly describe your symptoms, chosen treatment(s) and dates:
_____
_____
_____
_____

Respiratory Conditions

□ _____Asthma □ _____Chronic Sinusitis
□ _____Bronchitis □ _____Emphysema □ _____Pneumonia
□ _____Sleep Apnea □ _____Frequent or recurrent Colds/Flus
□ _____Other Please briefly describe your symptoms, chosen treatment(s) and dates:_____
_____
_____

Skin Conditions:

□ _____Eczema □ _____Psoriasis □ _____Dermatitis □ _____Hives □ _____Rash, undiagnosed □ _____Acne □ _____Skin Cancer (Melanoma) □ _____Skin Cancer (Squamous, Basal)□ _____Other Please briefly describe your symptoms, chosen treatment(s) and dates:
_____
_____

Neuro logic/Mood

□ _____Depression □ _____Anxiety □ _____Bipolar Disorder □

_____Schizophrenia □ _____Headaches□ _____Migraines □ _____ADD/ADHD □ _____Autism □ _____Mild Cognitive Impairment □ _____Memory problems □ _____Parkinson's Disease □ _____Multiple Sclerosis □ _____ALS □ _____Seizures □ _____Alzheimer's □ _____Other

Please briefly describe your symptoms, chosen treatment(s) and dates and N for Now and P for Past:

Miscellaneous:

□ _____Anemia □ _____Chicken Pox □ _____German Measles □ _____Measles □ _____Mononucleosis □ _____Mumps □ _____Sleep Apnea □ _____Whooping Cough □ _____Tuberculosis □ _____Known genetic variants (SNPs, polymorphisms, etc) □ _____Other Please briefly describe your symptoms, chosen treatment(s) and dates:_____

_____

_____

_____**33.Pleas**

e check frequency of the following:

Short term memory impairment □ yes □ no □ sometimes
Shortened focus of attention and ability to concentrate sometimes Coordination and balance problems □ yes □ no □ sometimes
Problems with lack of inhibition□ yes □ no □ sometimes
Poor organization abilities □ yes □ no □ sometimes
Problems with time management (late or forget appts) □ yes □ no □ sometimes
Mood instability□ yes □ no □ sometimes
Difficulty understanding speech and word finding □ yes □ no □ sometimes
Brain fog, brain fatigue□ yes □ no □ sometimes
Lower effectiveness at work, home or school□ yes □ no □ sometimes
Judgment problems like leaving the stove on, etc□ yes □ no □ sometimes

Health Hazards:

34. Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)? _____

35.Do odors affect you?_____

36.Are you or have you been exposed to second-hand smoke?_____

Oral Health History:

37.How long since you last visited the dentist?_____

What was the reason for that visit?
_____38
. In the past 12 months has a dentist or hygienist talked to you about your oral health, blood sugar or other health concerns?_____
(Explain.)_____
_____
_____
39.What is your current oral and dental regimen? (Please note whether this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)

40.Do you have any mercury amalgams? _____ (If no, were they removed?_____ If so, how?) _____ 41.Do you have any concerns about your oral or dental health?_____
__ 42.Is there anything else about your current oral or dental health or health history that you'd like us to know?_____

___ Lifestyle History:

43.Have you had periods of eating junk food, binge eating or dieting?_____
_____ List any known diet that you have been on for a significant amount of time._____
_____
_____
_____ 44.Have you used or abused alcohol, drugs, meds, tobacco or caffeine?_____ Do you still? _____
45.How do you handle stress?_____
_____
_____
_____

Sleep History:

46.Are you satisfied with your sleep?_____
47.Do you stay awake all day without dozing? _____
48.Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?_____
49.Do you fall asleep in less than 30 minutes?_____
50.Do you sleep between 6 and 8 hours per night? _____

For Women Only:

51.How old were you when you first got your period? _____

52.How are/were your menses?_____ Do/did you have PMS? _____Painful periods?_____ If so, explain._____

_____

_____

_____

_____ 53.In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability? _____ 54.Have you experienced any yeast infections or urinary tract infections?_____ Are they regular?_____ 55.Have you/do you still take birth control pills: _____ If so, please list length of time and type._____ 56.Have you had any problems with conception or pregnancy?_____

57.Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

_____

_____

Sexual History:

58.Do you have any concerns or issues with your sexual functioning that you'd like to share with us (pain with intercourse, dryness, libido issues, erectile dysfunction)?_____

_____ 59. N/A

Mental Health Status:

60.How are your moods in general?_____

Do you experience more anxiety, depression or anger than you would like?_____

__ 61.On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy._____ 62.At

what point in your life did you feel best? Why?

_____
_____
_____
_____

Other: _____63.Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life?_____ Explain, if no._____
_____
_____
_____ 64. Who in you family or on your health care team will be most supportive of you making dietary change?_____ 65. Please describe any other information you think would be useful in helping to address your health concern(s):_____
_____
_____
_____ 66.What are your health goals and aspirations?_____
_____
_____
_____
_ 67.Though it may seem odd, please consider why you might want to achieve that for yourself:

_____
_____
_____
_____