General Information

Name____ Age _____

Date of Birth __________________ Email____

Insurance _______________________________ Primary Care _______________________________

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Severity: 1 = Mild 2 = Moderate 3 = Severe
Success: 1= Excellent 2 = Good 3 = Fair

Describe Problem Severity	1	2	3	Prior Treatment Success	1	2	3
ie. Post Nasal Drip OR IBS	*X*			*ie. Medication OR Elimination Diet*	*X*		

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Medications

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems? **Yes** **No**

If yes, describe: ____

____

Have you used any of these regularly or for a long time:

NSAIDs (Advil,Aleve,etc.), Motrin,Aspirin? **Yes** **No**

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? **Yes** **No**

Tylenol (acetaminophen)? **Yes** **No**

How many times have you taken antibiotics?

	<5	>5	Reason
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics? **Yes** **No**

If yes, explain:____

____

Current Exercise Program

Activity	Type	Time per week	Duration
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sport/Leisure (ie golf)			
Other			

Do you feel motivated to exercise? **A little** **No** **Yes**
Are there any problems that limit exercise? **Yes** **No**

If yes, explain:____

____

Sleep

How many hours of sleep do you get each night on average? ______________________

Do you have problems falling asleep? **Yes** **No**
Do you have problems with insomnia? **Yes** **No**
Do you feel rested upon awakening? **Yes** **No**
Do you use sleeping aids? **Yes** **No**

Staying asleep? **Yes** **No**
Do you snore? **Yes** **No**

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

Vegetarian Vegan Allergy Elimination Low Fat Low Carb High Protein
Blood Type Low sodium No Dairy No Wheat Gluten Free Keto

Other: ____

Do you have sensitivities to certain foods? **Yes** **No**

If yes, list food and symptoms:

____

____

Do you have an aversion to certain foods? **Yes** **No**

If yes, explain:

____

____

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

Monosodium glutamate (MSG) Artificial sweeteners Garlic/onion Cheese Citrus foods

Chocolate Alcohol Red wine Sulfite–containing foods (wine, dried fruit, salad bars)

Preservatives Food colorings Other food substances: ____________________

Are there any foods that you crave or binge on? **Yes** **No**

If yes, what foods?

____

Do you eat 3 meals a day? **Yes** **No** If no, how many ____________________

Does skipping a meal greatly affect you? **Yes** **No**

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

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

- ☐ Fast eater
- ☐ Eat too much
- ☐ Late-night eating
- ☐ Dislike healthy foods
- ☐ Time constraints
- ☐ Travel frequently
- ☐ Eat more than 50% of meals away from home
- ☐ Healthy foods not readily available
- ☐ Poor snack choices
- ☐ Significant other or family members don't like healthy foods
- ☐ Significant other or family members have special dietary needs
- ☐ Love to eat
- ☐ Eat because I have to
- ☐ Have negative relationship to food
- ☐ Struggle with eating issues
- ☐ Emotional eater (eat when sad, lonely, bored, etc.)
- ☐ Eat too much under stress
- ☐ Eat too little under stress
- ☐ Don't care to cook
- ☐ Confused about nutrition advice

Readiness Assessment and Health Goals

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

1 2 3 4 5 Significantly modify your diet
1 2 3 4 5 Take several nutritional supplements each day
1 2 3 4 5 Keep a record of everything you eat each day (3-7 day food diary)
1 2 3 4 5 Modify your lifestyle (e.g., work demands, sleep habits)
1 2 3 4 5 Practice a relaxation technique
1 2 3 4 5 Engage in regular exercise

Rate on a scale of 5 (very confident) to 1 (not confident at all):

1 2 3 4 5 How confident are you of your ability to organize and follow through on the above health-related activities?

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through ____

____

____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

1 2 3 4 5 At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

1 2 3 4 5 How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program?

Health Goals

What do you hope to achieve in your visit with us?

____

____

____

Other Comments

____

____

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