WINDSOR
WELLNESS

NUTRITION INTAKE FORM

Welcome to Windsor Wellness!

Before your initial visit, please complete this new patient form to ensure we can provide you with the best care.

How did you hear about us?					
	Word of Mouth		Windsor Wellness Website		Health Practitioner
	Walk-by		Internet Search		Insurance Company
	Postcard or Brochure		Social Media		Class/Workshop/Retreat
	Magazine Ad		Other:		

General Patient Information				
Patient Name:				SS#:
Address:			City, State, Zip:	
Date:	DOB:	Age:	Gender:	Email:
Home Phone:		Work Phone:		Cell Phone:
Occupation:				
Emergency Contact:			Relationship:	
Home Phone:		Work Phone:		

Status					
	Married		Separated		Widowed
	Partnership		Divorced		Single

Live with					
	Spouse		Parents		Friends
	Partner		Children		Alone

MEDICAL DIAGNOSES

Do you currently have an unresolved medical issue(s) spanning 1 year or more?		Y		N
Have you seen more than two specialists for this problem in the same time period?		Y		N

Please List All Medical Diagnoses (Including high blood pressure, high cholesterol, diabetes, migraines, etc.)		
1.	4.	7.
2.	5.	8.
3.	6.	9.

SURGERIES / HOSPITALIZATIONS

Please List All Surgeries / Hospitalizations (Any childbirth, emergencies, etc.)		
1.	4.	7.
2.	5.	8.
3.	6.	9.

THERAPIES

Please List All Other Therapies You Are Using		
1.	4.	7.
2.	5.	8.
3.	6.	9.

MEDICATIONS

Please List All Medications (Including laxatives, appetite suppressants, tranquilizers, pain relievers, antacids, sleeping aids, birth control, cortisone, etc.)		
Medication	*Start Date (month/year)*	*End Date (month/year)*

HEALTH CONCERNS

What are your most important health concerns? List in order of importance	
Health Concern:	*Date of Onset:*
1.	
2.	
3.	
4.	
5.	

FAMILY HEALTH INFORMATION

Information about your family members will give us a better picture of your total health.		
Name:	*Relation:*	*Past and Present Health Problems:*

NUTRITION HISTORY

Have you ever had a nutrition consult?		Y	N
Have you made changes in your eating habits because of your health?		Y	N

If yes, please describe:

Do you currently follow a special diet or nutritional program?		Y	N

If yes, please check all that apply:

	Low Fat		Low Carbohydrate		High Protein
	Low Sodium		Diabetic		Dairy-free
	Wheat-free		Gluten-free		Vegetarian
	Vegan		Ultrametabolism		Other:

Type of program for Weight Maintenance:

Do you drink water?		Y	N

If yes, amount consumed in a 24 hour period:

Height and Weight History

Height (feet / inches):	Current Weight:
Highest Adult Weight:	Usual Weight +/- 5 lbs:

Weight Fluctuations (> 10 lbs.)		Y	N

Lowest Adult Weight:	Desired Weight Range +/- 5lbs:	Body Fat %

How Often do you weigh yourself?

	Daily		Weekly		Monthly
	Rarely		Never		

Exercise

Do you exercise?		Y	N

If yes, please describe how often:

Dietary Habits

Do you avoid any particular foods?		Y	N

If yes, type and reason:

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

Do you grocery shop?		Y	N

If no, who does the shopping?

Do you cook?							Y	N
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:			
	Fast eater		Erratic eating pattern
	Eat too much		Late night eating (later than 7:30 PM)
	Dislike healthy food		Time constraints
	Eat more than 50% meals away from home		Travel frequently
	Non-availability of healthy foods		Do not plan meals or menus
	Reliance on convenience items		Poor snack choices
	Significant other or family members don't like healthy foods		Eat because I have to
	Significant other or family members have special dietary needs or food preferences		Emotional eater (eat when sad, lonely, depressed, bored)
	Love to eat		Struggle with eating issues
	Have a negative relationship to food		Eat too little under stress
	Eat too much under stress		Eat in the middle of the night
	Don't care to cook		Confused about nutrition advice

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

Smoking								
Currently Smoke?							Y	N
If yes, what type:		Cigarettes		Cigars		Pipes		
How many years?	Packs per day:			Attempts to quit:				
Previous Smoker?							Y	N
If yes, how many years?	Packs per day:			Second Hand Smoke Exposure?				

ALLERGIES / SENSITIVITIES

Please List All Allergies / Sensitivities to drugs and other substances (Including food, environmental, chemicals, dust, mold, etc.)		
1.	3.	5.
2.	4.	6.

Blood Type:								
		O+		A+		B+		AB+
		O-		A-		B-		AB-
						Unknown		

DENTAL HISTORY

Do you have Silver Mercury Fillings? If so, how many:		Y		N
Gold Fillings		Y		N
Implants		Y		N
Bleeding Gums		Y		N
Problems with Chewing		Y		N
Root Canals		Y		N
Gingivitis		Y		N
Tooth Pain		Y		N
Do you floss regularly?		Y		N

PATIENT BIRTH HISTORY

	Term
Pregnancy Complications:	
	Premature
Birth Complications:	
	Breast Fed
If so, how long:	
	Bottle Fed
Age at introduction of Solid Foods:	
Age at introduction of Dairy:	
Age at introduction of Wheat:	

Did you eat a lot of candy or sugar as a child?		Y		N
Vaginal Birth		Y		N
Cesarean Section		Y		N

GYNECOLOGIC HISTORY

(for women only)

Obstetric History (Check box if yes and provide number of)				
Pregnancies		Y		#
Caesarean		Y		#
Vaginal Deliveries		Y		#
Miscarriage		Y		#
Abortion		Y		#
Living Children		Y		#

MEDICAL HISTORY AND SYMPTOM REVIEW

Check appropriate box and provide date of outset

	On-going Condition	Past Condition	Date of Onset
Neurologic / Nerves / Mood			
Depression			
Anxiety			
Bipolar Disorder			
Schizophrenia			
Headaches			
Migraines			
ADD/ADHD			
Autism			
Seizures			
Nervousness			
Tension			
Easily Stressed			
Difficulty:			
Concentrating			
With Balance			
With Thinking			
Difficulty:			
With Judgment			
Speech			
Memory			
Dizziness (Spinning)			
Vertigo			
Fainting			
Irritability			
Light-headedness			
Numbness			
Seizures			
Tingling			
Tremor/Trembling			
Mood Swings			
Other			

	On-going Condition	Past Condition	Date of Onset
Respiratory			
Difficulty Breathing			
Shortness of Breath			
Persistent Cough (Dry, Productive)			
Frequent Colds			
Nasal Stuffiness			
Post Nasal Drip			
Sinus Stuffiness			
Sinus Infection			
Snoring			
Wheezing			
Winter Stuffiness			
Asthma			
Chronic Sinusitis			
Bronchitis			
Emphysema			
Pneumonia			
Tuberculosis			
Sleep Apnea			
Other			
Cardiovascular			
Heart Attack			
Other Heart Disease			
Stroke			
Arrhythmia (irregular heart rate)			
Hypertension (high blood pressure)			
Angina/Chest Pain			
Deep Leg Pain			
Easy Bleeding			
Easy Bruising			
Anemia			
Blood Clots			

	On-going Condition	Past Condition	Date of Onset
Fainting			
Breathlessness			
Palpitations			
Swollen Ankles/Feet			
Other			
Gastrointestinal			
Irritable Bowel Syndrome			
Inflammatory Bowel Disease			
Crohn's Disease			
Ulcerative Colitis			
Gastritis or Peptic Ulcer Disease			
GERD (reflux)			
Gastroenteritis			
Nausea			
Constipation			
Intestinal Bloating			
Burping			
Liver Disease/Jaundice			
Lower Abdominal Pain			
Gallbladder Disease			
Cramps			
Diarrhea			
Alternating Diarrhea and Constipation			
Difficulty Swallowing			
Excess Flatulence/Gas			
Foods "Repeat" (Reflux)			
Heartburn			
Indigestion			
Upper Abdominal Pain			
Vomiting			
Other			
Genital and Urinary Systems			
Kidney Stones			
Gout			

	On-going Condition	Past Condition	Date of Onset
Interstitial Cystitis			
Frequent Urinary Tract Infections			
Frequent Yeast Infections			
Erectile Dysfunction or Sexual Dysfunction			
Bed Wetting			
Hesitancy (trouble getting started)			
Infection			
Leaking Incontinence			
Pain/Burning			
Prostate Infection			
Urgency			
Frequency at Night			
Increased Frequency			
Kidney Stones			
Other			
Musculoskeletal / Pain			
Osteoarthritis			
Fibromyalgia			
Chronic Pain			
Back Muscle Spasm			
Calf Cramps			
Chest Tightness			
Foot Cramps			
Joint Deformity			
Joint Pain			
Joint Redness			
Joint Stiffness			
Muscle Pain			
Muscle Spasms			
Muscle Twitches:			
Around Eyes			
Arms or Legs			
Broken Bones			
Arthritis			

	On-going Condition	Past Condition	Date of Onset
Sciatica			
Muscle Weakness			
Neck Muscle Spasm			
Tendonitis			
Tension Headache			
TMJ Problems			
Other			
Inflammatory / Autoimmune			
Chronic Fatigue Syndrome			
Autoimmune Disease			
Rheumatoid Arthritis			
Lupus SLE			
Endocrine			
Cold Hands & Feet			
Low Blood Pressure			
Difficulty Falling Asleep			
Early Waking			
Fatigue			
Chronic Infection			
Slow Wound Healing			
Head, Eyes & Ears			
Ear Fullness			
Ear Pain			
Ear Ringing / Buzzing			
Glasses / Contacts			
Hearing Loss			
Hearing Problems			
Headache			

	On-going Condition	Past Condition	Date of Onset
Migraine			
Sensitivity to Loud Noises			
Vision Problems (other than glasses)			
Head Injury			
Teeth Grinding			
Jaw Problems			
Jaw Clicks			
Dizziness			
Lymph Nodes			
Enlarged / Neck			
Tender / Neck			
Other Enlarged / Tender			
Male Reproductive			
Ejaculation Problems			
Prostate or Urinary Infection			
Hernia			
Female Reproductive			
Breasts Cysts			
Breast Lumps			
Breast Tenderness			
Ovarian Cyst			
Menses:			
Cramps			
Heavy Periods			
Irregular Periods			
No Periods			
Scanty Periods			
Spotting Between			

Comments

Important office note: Because many of our patients are infants or those that suffer from allergies, we ask that you kindly refrain from wearing fragrance—including scented lotions—to your appointment. Thank you!

Print Name: ..... Signature: ..... Date: .....