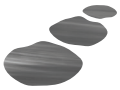

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NEW PATIENT INTAKE FORM

First Name _____ Middle Name_____ Last Name_____

Address _____ City _____ State_____Zip:_____

Please indicate your preferred method of contact: home work cell email

Home Phone (_____)_____-_____ Birth Date _____/_____/_____ Age _____

Work Phone (_____)_____-_____ Email address: _____

Cell Phone (_____)_____-_____ Height: ___ ′ ____″ Weight: _____ Sex: _____

Blood Type (Please circle): A / AB / B / O / Unknown

Occupation _____ Relationship Status _____

Do you have children? Yes No Age of children _____

Are you pregnant? Yes No Due Date _____

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Sarah, age 7, sister

_____

_____

Emergency Contact: Name _____ Relationship _____ Phone _____

Primary Care Provider _____ Date of last physical exam _____

Other doctors or practitioners you see _____

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Please explain the reason(s) for your appointment today:

How long have you been experiencing this issue:

Do you know the source or cause of this issue?_____

If yes, please explain:

What symptoms are you experiencing with this issue:

If experiencing physical pain, on a scale of 1-10, how would you rate your pain on average?

_____

If experiencing emotional upset, on a scale of 1-10, how would you rate your emotional intensity?

_____

Have you sought professional assistance for this issue before? YES NO

If yes, what type of therapy have you experienced?

Did you find this or these therapies helpful? (please describe)

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My food and nutrition-related goals are...

My overall, health goals are...

If I could change three things about my health and nutritional habits, they would be...

1.
2.
3.

The biggest challenge(s) to reaching my nutrition goals is/are:

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals...

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to...	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					

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Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or symptoms (specify which relative and the date of diagnosis).
**Relatives include: parents, grandparents, siblings.*

Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
☐ Allergies (please specify type of allergy)			
☐ Anemia			
☐ Anxiety or Panic Attacks			
☐ Arthritis (osteoarthritis or rheumatoid)			
☐ Asthma			
☐ Autoimmune condition (specify type)			
☐ Bronchitis			
☐ Cancer			
☐ Chronic Fatigue Syndrome			
☐ Crohn's Disease or Ulcerative Colitis			
☐ Depression			
☐ Diabetes (Specify: Type I, II, Prediabetes, Gestational Diabetes)			
☐ Dry, itchy skin, rashes, dermatitis			
☐ Eczema			
☐ Emphysema			
☐ Epilepsy, convulsions, or seizures			
☐ Eye Disease (please specify)			
☐ Fibromyalgia			
☐ Food Allergies or Sensitivities			
☐ Fungal Infection (athlete's food, ringworm, other)			
☐ Gallbladder Disease/Gallstones (specify)			
☐ Gout			
☐ Heart attack/Angina			
☐ Heartburn			
☐ Heart disease (specify)			
☐ Hepatitis			
☐ High blood fats (cholesterol, triglycerides)			
☐ High blood pressure (hypertension)			
☐ Hypoglycemia (low blood sugar)			
☐ Intestinal Disease (specify)			
☐ Infammatory Bowel Disease (Crohn's or Ulcerative Colitis)			
☐ Irritable bowel syndrome			
☐ Kidney disease/failure or Kidney stones			
☐ Lung disease (specify)			
☐ Liver disease			
☐ Mononucleosis			
☐ Osteoporosis			
☐ PMS			
☐ Polycystic Ovarian Syndrome			

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Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
☐ Pneumonia			
☐ Prostate Problems			
☐ Psychiatric Conditions			
☐ Seizures or epilepsy			
☐ Sinusitis			
☐ Sleep apnea			
☐ Stroke			
☐ Thyroid disease (hypo or hyperthyroid)			
☐ Urinary Tract Infection			
☐ Other (describe)			
Injuries	**Age**	**Describe/Specify**	
☐ Back injury			
☐ Broken (specify)			
☐ Head injury			
☐ Neck injury			
☐ Other (describe)			
Diagnostic Studies	**Age at study**	**Describe/Specify**	
☐ Barium Enema			
☐ Bone Scan			
☐ CAT Scan: Abdom., Brain, Spine (specify)			
☐ Chest X-ray			
☐ Colonoscopy or Sigmoidoscopy (specify)			
☐ EKG			
☐ Liver scan			
☐ NMR/MRI			
☐ Upper GI Series			
☐ Other (describe)			
Operations	**Age at operation**	**Describe/Specify**	
☐ Dental Surgery			
☐ Gal Bladder			
☐ Hernia			
☐ Hysterectomy			
☐ Tonsillectomy			
☐ Other (describe)			

Please complete the following information concerning your family's health history:

	If Living		If Deceased			If Living		If Deceased	
	Age	Health	Age at Death	Cause		Age	Health	Age at Death	Cause
Father					Spouse/Partner				
Mother					Children				
Siblings									

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MEDICAL SYMPTOMS QUESIONNAIRE

Rate each of the following symptoms based upon your typical health profile for the past 30 days. If you have been having recent or somewhat severe health symptoms, please indicate that you will fill out the questionnaire for the past 48 hours.

☐ **Past 30 days** ☐ **Past 48 days**

Point Scale

0 - **Never** or **almost never** have the symptom
1 - **Occasionally** have it, effect is **not severe**
2 - **Occasionally** have it, effect is **severe**
3 - **Frequently** have it, effect is **not severe**
4 - **Frequently** have it, effect is **severe**

HEAD
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia **Total** _____

EYES
_____Watery or itchy eyes
_____Swollen, red, sticky eyelids
_____Dizziness
_____Insomnia **Total** _____

_____Swollen, reddened or sticky eyelids
_____Bags or dark circles under eye
_____Blurred or tunnel vision
(does not include near or far-sightedness) **Total** _____

EARS
_____Itchy ears
_____Earaches, ear infections
_____Drainage from ear
_____Ringing in ears, hearing loss **Total** _____

NOSE
_____Stuffy nose
_____Sinus problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucus formation **Total** _____

MOUTH/THROAT
_____Chronic cough
_____Gagging, frequent need to clear throat
_____Sore throat, hoarseness, loss of voice
_____Swollen or discolored tongue, gums, lips
_____Canker sores **Total** _____

SKIN
_____Acne
_____Hives, rashes, dry skin
_____Hair loss
_____Flushing, hot flashes
_____Excessive sweating **Total** _____

HEART
_____Irregular or skipped heartbeat
_____Rapid or pounding heartbeat
_____Chest pain **Total** _____

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MEDICAL SYMPTOMS QUESIONNAIRE

LUNGS
_____Chest congestion
_____Asthma, bronchitis
_____Shortness of breath
_____Difficulty breathing **Total** _____

DIGESTIVE TRACT
_____Nausea, vomiting
_____Diarrhea
_____Constipation
_____Bloated feeling
_____Belching, passing gas
_____Heartburn
_____Intestinal/stomach pain **Total** _____

JOINT/MUSCLE
_____Pain or aches in joints
_____Arthritis
_____Stiffness or limitation of movement
_____Pain or aches in muscles
_____Feeling of weakness or tiredness **Total** _____

WEIGHT
_____Binge eating/drinking
_____Craving certain foods
_____Excessive weight
_____Compulsive eating
_____Water retention
_____Underweight **Total** _____

ENERGY/ACTIVITY
_____Fatigue, sluggishness
_____Apathy, lethargy
_____Hyperactivity
_____Restlessness **Total** _____

MIND
_____Poor memory
_____Confusion, poor comprehension
_____Poor concentration
_____Poor physical coordination
_____Difficulty in making decisions
_____Stuttering or stammering
_____Slurred speech
_____Learning disabilities **Total** _____

EMOTIONS
_____Mood swings
_____Anxiety, fear, nervousness
_____Anger, irritability, aggressiveness
_____Depression **Total** _____

OTHER
_____Frequent illness
_____Frequent or urgent urination
_____Genital itch or discharge **Total** _____

GRAND TOTAL_____

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MEDICATION, SUPPLEMENT, AND ANTIBIOTIC INTAKE:

Please provide the names of medications, supplements, and/or antibiotics that you are currently taking:

Medication/Supplement/ Antibiotic	Dose	Units	Frequency	Start Date	Stop Date
Example: *One-a-Day (brand) Men's Multivitamin*	*1200*	*Mg*	*Daily*	*8/12/2015*	*current*

Are you allergic to any medications? Yes No Please list: _____

Please indicate how often you have taken antibiotics during each life stage:

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

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LIFESTYLE

Physical Activity: Using the table, please describe your physical activity.

Activity	Type/Intensity (low-moderate-high)	# Days per week	Duration (minutes)
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-training (weight lifting, pilates, some yoga)			
Sports or Leisure			
Other (specify/describe)			

Does anything limit you from being physically active?

_____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work_____ Family_____ Social_____ Financial_____ Health_____ Other_____

What helps you to unwind?_____

On average, how many hours of sleep do you get? Weekdays_____ Weekends_____

Do you smoke? ☐Never ☐In the past ☐Currently How long?_____

Alcohol use ☐Never ☐In the past ☐Currently Type/amount/frequency_____

Drug use ☐Never ☐In the past ☐Currently ☐Prefer not to discuss Type/frequency_____

WEIGHT HISTORY

Would you like to be weighed today? ☐Yes ☐No

Height _____ Current Weight _____ Desired Body Weight _____

Highest Adult Weight _____ When?_____ Weight 1 year ago _____

Have you had any recent changes in your weight that you are concerned about? ☐Yes ☐No

If yes, please explain:_____

DIGESTIVE HISTORY

Do you associate any digestive symptoms with eating certain foods? ☐Yes ☐No

Please explain:_____

_____

How often do you have a bowel movement? _____

If you take laxatives, what type/brand and how often?

_____

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Would you describe your stools are hard, soft, or loose? (circle one)

Please indicate how often you experience the following symptoms:

Heartburn	Often	Sometimes	Rarely
Gas	Often	Sometimes	Rarely
Bloating	Often	Sometimes	Rarely
Stomach Pain	Often	Sometimes	Rarely
Nausea/Vomiting	Often	Sometimes	Rarely
Diarrhea	Often	Sometimes	Rarely
Constipation	Often	Sometimes	Rarely

DIET HISTORY

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)? ☐Yes ☐No If so, please describe _____

Please list any food allergies, sensitivities or intolerances _____

_____

Who prepares the majority of your meals? _____ Who shops for food? _____

Where do you shop for food? _____

What percent of the foods you eat are... whole _____% organic_____% convenience _____%

If you do, how much time do you spend cooking/preparing meals each day? _____

Please indicate the materials you use for cooking and food storage:

☐Plastic ☐Glass ☐Aluminum ☐Styrofoam
☐Stainless Steel ☐Cast-iron ☐Teflon/non-stick ☐Ceramic

Do you find cooking difficult? ☐Yes ☐No Please describe _____

INTAKE INFORMATION

If you follow a special diet/nutritional program, check the following that apply:

☐Low Fat ☐Low Carb ☐High Protein ☐Low Sodium
☐No Gluten ☐Vegetarian ☐Vegan ☐Diabetic
☐No Dairy ☐No Wheat ☐Weight Loss ☐Other

Which meals do you eat regularly, check all that apply:

☐Breakfast ☐Lunch ☐Dinner/Supper ☐Snacks (time_____)

The nutrition/eating habits that are most challenging for me: _____

_____

_____

The nutrition/eating habits that I am most pleased with: _____

_____

_____

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Beverage Intake: Please indicate the beverages you drink, and how often you drink them. Fill in the "Daily Amount", "Weekly Amount", and/or "Monthly Amount"

Beverage Type	Daily Amount	Weekly Amount	Monthly Amount
Example: *Coffee:* ☑ *reg* ☐ *decaf* ☐ *latte*	*2 - 8 oz. cups*	———	———
Water: ☐ tap ☐ filtered ☐ bottled			
Coffee: ☐ reg ☐ decaf ☐ latte			
Water: ☐ tap ☐ filtered ☐ bottled			
Juice: ☐ natural ☐ fruit drinks			
Soda: ☐ regular ☐ diet			
Milk: ☐ whole ☐ 2% ☐ 1% ☐ skim			
Milk alternative Type _____			
Alcohol: ☐ wine ☐ beer ☐ liquor			
Other _____			

Food Intake: Please indicate the frequency that you eat the following:

Illness/Disease/Symptom	Never	2-3 times/mo.	1 time/week	2-3 times/week	1 times/day	2-3 time/day
Fast food						
Restaurant food						
Vending machine food						
Cafeteria or buffet food						
Frozen meals						
Home-cooked meals						
Leftovers						
Beef (hamburger, steak, etc.)						
Pork (chop, loin, ham, bacon, etc.)						
Liver						
Lamb						
Poultry (chicken, turkey, etc.)						
Deli meat, type:						
Fish, type:						
Soyfoods, type:						
Beans, type:						
Crackers, type:						
Cookies, cakes, muffins						
Whole grains, type:						
Fresh/Raw vegetables						
Cooked vegetables						
Fruit, fresh or frozen						
Canned Vegetables or Fruit						
Margarine						
Dairy (Milk, yogurt, cheese, butter)						
French fries						
Fried meat (chicken, fish)						
Foods with added sweeteners/sugar, type:						
Artificial sweeteners, type:						
Meal Replacements, type:						

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Food cravings _____

_____

Food dislikes _____

_____

Eating Style: Based on how you eat on a regular basis, please check all that apply:

- ☐ Fast Eater
- ☐ Erratic eater
- ☐ Emotional eater (stressed, bored, sad, etc.)
- ☐ Late night-eater
- ☐ Time constraints
- ☐ Dislike "healthy" food
- ☐ Travel frequently
- ☐ Do not plan meals/menus
- ☐ Rely on convenience items
- ☐ Family member(s) have different tastes
- ☐ Love to eat
- ☐ Eat too much
- ☐ Eat because I have to
- ☐ Negative relationship with food
- ☐ Struggle with eating issues
- ☐ Confused about food/nutrition
- ☐ Frequently eat fast food
- ☐ Poor snack choices

The food/nutrition questions that I would like to ask are: _____

_____

_____

_____

_____

_____

_____

_____

_____