



## Health History

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell/Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Relationship Status \_\_\_\_\_ Children? \_\_\_\_\_ Occupation \_\_\_\_\_ Hours per week you work \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Are you currently under a doctor's care or any other health professional? Y N Please provide name and reason:

\_\_\_\_\_

How did you hear about us? (doctor, nurse, flyer, website, friend, other) \_\_\_\_\_

---

What is your primary reason(s) for seeking nutrition counseling? Please describe current condition.

What do you feel are your biggest nutritional challenges and difficulties?

Do you have any chronic health problems or other diagnoses, (such as anemia, high cholesterol, high blood pressure, hypoglycemia, gastrointestinal problem, etc.)? Please include date diagnosed and all current and past treatment.

Please list all vitamins, herbs or medications that **you** are currently taking or have taken in the past 2 months:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all vitamins, herbs or medications that **your spouse** is taking or has taken in the past 2 months:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you experience chronic pain anywhere in your body? Y N Where? \_\_\_\_\_

On a scale of 1-10, how would you rate your pain? \_\_\_\_\_

How would you describe your overall general health now? Poor Fair Good Excellent

How has it been most of your life? Poor Fair Good Excellent

Do you sleep well? \_\_\_\_\_ Do you wake up at night? \_\_\_\_\_ Do you feel refreshed when you wake up? \_\_\_\_\_

Do you use medication for sleep? Y N If so, what kind and how often? \_\_\_\_\_

Do you have good energy levels? Y N Inconsistent

Current Height:\_\_\_\_\_ Current Weight:\_\_\_\_\_ Weight six months ago:\_\_\_\_\_ One year ago:\_\_\_\_\_

Do you consider yourself: Underweight Overweight Just Right

Please circle:

I have / have not previously used diet or exercise to lose or gain weight.

I have / have not previously used medications or supplements to lose or gain weight.

Do you diet frequently?\_\_\_\_\_ Are you currently on a diet?\_\_\_\_\_ If yes, please describe:\_\_\_\_\_

### General Medical History

Please indicate if you currently have or have had *in the past year* any of the following symptoms or diagnoses with a letter "S" for self. Also, please mark any illnesses that you believe one or more of your parents/grandparents/siblings have had with an "F" for family:

___ Acne breakouts	___ Excessive fatigue	___ Irritable/depressed	___ Skin ulcers
___ Alcoholic	___ Facial hair growth	___ during menses	___ STD
___ Allergies	___ Fainting/dizzy spells	___ Leg/muscle cramps	___ Thyroid disease
___ Anemia	___ Feel hot often	___ Less than 1 bowel	___ Ulcerative Colitis
___ Antibiotic use (extended)	___ Feel cold often	___ movement per day	___ Unexplained Weight Gain
___ Anxiety	___ Fibroids	___ Liver Disease	___ Yeast Infections (chronic)
___ Autoimmune disease	___ Gastritis	___ Low Blood Pressure	
___ Bloating/gas	___ Hair loss/thinning	___ Low Cholesterol	
___ Candida Albicans	___ Headaches	___ Low libido	
___ Celiac disease	___ Heartburn/reflux	___ Lupus	
___ Chron's Disease	___ Hemorrhoids	___ Menstrual clotting	
___ Colds/flu	___ Herpes	___ Menstrual cramps	
___ Constipation	___ High Cholesterol	___ Migraines	
___ Depression	___ High Blood Pressure	___ Multiple Sclerosis	
___ Diarrhea	___ Hot Flashes	___ Nausea	
___ Diverticulosis	___ Hypoglycemic	___ Nervous breakdown	
___ Drug Addictions	___ Hypothyroid	___ Nervousness	
___ Dry skin	___ Hyperthyroid	___ Numbness	
___ Dry hair	___ Insomnia	___ Polycystic Ovarian Syndrome	
___ Eczema	___ Irregular menses	___ Rheumatoid arthritis	
___ Endometriosis	___ Irritable Bowel Syndrome	___ Sciatica	

---

### REPRODUCTIVE HISTORY

#### Women:

Regular menses cycle? Yes \_\_\_ No \_\_\_; # of days between periods?\_\_\_; Length of period?\_\_\_\_\_; Clots?\_\_\_\_\_

Flow is Heavy \_\_\_ Medium \_\_\_ Light \_\_\_; Pain or Cramping? Yes \_\_\_ No \_\_\_; Abnormal Discharge? Yes\_\_\_ No \_\_\_

PMS symptoms:\_\_\_\_\_

Date of last period\_\_\_\_\_

If you use a contraceptive, what type?\_\_\_\_\_ For how long?\_\_\_\_\_ Symptoms:\_\_\_\_\_

Number of pregnancies:\_\_\_\_\_ Miscarriages:\_\_\_\_\_ C-sections:\_\_\_\_\_

Are you trying to conceive?\_\_\_\_\_ If yes, how long have you been trying to conceive?\_\_\_\_\_

Have you sought Assisted Reproductive Technology previously?\_\_\_\_\_ If yes, what have you done & results?\_\_\_\_\_

Has your partner been tested for any fertility-related problems?\_\_\_\_\_ If yes, what were the results?\_\_\_\_\_

Menopause?\_\_\_\_\_ Age at menopause: \_\_\_\_\_ Symptoms: \_\_\_\_\_

Please rate your current sexual libido on a scale of 1-10 (10 being the highest):\_\_\_\_\_

---

**NUTRITION INFORMATION**

On a scale of 1-10 (10 being extremely healthful), how do you rate your diet? \_\_\_\_\_ / 10

Please describe any current dietary restrictions that you may have: \_\_\_\_\_  
 \_\_\_\_\_

Do you have food allergies? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

Please describe what you think are your “worst” food habits: \_\_\_\_\_

What foods do you crave? \_\_\_\_\_

What foods do you avoid? Why? \_\_\_\_\_

Do you snack during the day? \_\_\_\_\_ Describe: \_\_\_\_\_

Please describe what a “typical” day of food consists of for you (i.e., breakfast = cereal with milk and coffee, lunch = salad with low-fat dressing and half turkey sandwich, dinner = spaghetti with meatballs, garlic bread and wine, snack = almonds and an apple): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How many glasses of water do you drink per day? \_\_\_\_\_ What is your drinking water source? Tap Bottled  
 Filtered Reverse Osmosis Distilled Well

**Food Frequency:** How often do you eat the following foods? Place a check mark in the appropriate box.

FOODS	NEVER	<1x/MONTH	<1x/WEEK	2-4x/WEEK	DAILY
Fresh vegetables					
Fresh fruit					
Milk					
Cheese					
Yogurt					
Ice cream					
Soy/soy foods					
Nuts & seeds					
Nut butters (i.e. peanut butter)					
Beans/legumes (i.e. hummus)					
Whole wheat					
Other whole grains (i.e. brown rice, quinoa, oatmeal)					
“White” processed foods (i.e. pasta, crackers, chips)					

Boxed cereal					
Fish					
Red meat					
Chicken/turkey					
Pork/ham/bacon					
Eggs					
Butter					
Margarine					
Olive oil					
Fried foods					
Sweets (dessert, candy, cookies, chocolate)					
Artificial Sweetener (i.e. Splenda, Equal)					
Alcohol					
Caffeine					
Soda/diet soda					

Any foods that are not listed that are consumed regularly \_\_\_\_\_

Any beverages that are not listed that are consumed regularly \_\_\_\_\_

**Meal Planning:**

Who plans your meals? \_\_\_\_\_ Who cooks? \_\_\_\_\_ Who shops? \_\_\_\_\_ Do you like to cook? \_\_\_\_\_

If no, would you be willing to learn some basic cooking techniques? \_\_\_\_\_

Where do you do most of your grocery shopping? \_\_\_\_\_

**Dining Habits:**

How many times per week do you eat the following at home? away from home?

Breakfast \_\_\_/\_\_\_ Lunch \_\_\_/\_\_\_ Dinner \_\_\_/\_\_\_

How often do you eat:

At fast food restaurants? \_\_\_\_\_

At casual dining restaurants? \_\_\_\_\_

At business meetings? \_\_\_\_\_

At "fine dining" restaurants? \_\_\_\_\_

"On the run" (rushed, in the car, standing in the kitchen, etc.) \_\_\_\_\_

In front of the t.v.? \_\_\_\_\_

What percentage of your food is freshly prepared? \_\_\_\_\_%

What percentage of the food that you prepare comes frozen, canned, in a box or pre-made? \_\_\_\_\_%

What percentage of your food do you buy organic? \_\_\_\_\_%

Are you conscious of what and how much you put in your mouth? Y N

Do you consider yourself a *fast-eater* or a *slow-eater* (circle one)? Do you chew your food thoroughly? \_\_\_\_\_

Are you often ravenous before meals? Y N

Are you often overly full at the end of each meal? Y N

**Sugar Consumption:**

How often do you consume white/refined sugar or white/refined sugar products? Often\_\_\_ Binge\_\_\_ Moderate\_\_\_  
Rarely\_\_\_ None\_\_\_ Eat daily\_\_\_ Eat several times weekly\_\_\_

How does eating sugar make you feel, both physically and emotionally/mentally? \_\_\_\_\_

Do you use other sweeteners besides sugar? If so, which ones? \_\_\_\_\_

---

**EXERCISE**

Do you exercise? Y N If so, how often? Daily Every other day Twice per week Once per week Rarely/Never

What type of exercise do you do? \_\_\_\_\_

How do you feel about your amount of exercise? Less than I need More than I need Just Right

---

**EMOTIONAL STATE**

Which of these apply to you?

Happy Sad Depressed Anxious Fearful Angry Content Joyful Judgmental Irritated

On a scale of 0 (no stress) to 10 (FREAKING OUT), how do you rate your overall daily stress level? \_\_\_\_\_

How would you rate your level of happiness in life (scale of 1 – 10, 10 being the highest): \_\_\_\_\_

How would you rate your level of happiness in your job (scale of 1 – 10, 10 being the highest): \_\_\_\_\_

Please list the major stressors in your life: \_\_\_\_\_  
\_\_\_\_\_

What activities do you engage in to counterbalance stress in your life? \_\_\_\_\_  
\_\_\_\_\_

If you could change one thing in your life right now, what would it be? \_\_\_\_\_  
\_\_\_\_\_

Do you ever eat when you are sad, worried, or upset? (If yes, please describe.) \_\_\_\_\_  
\_\_\_\_\_

What do you do to help you relax, fall asleep or “wind down” at the end of a stressful day? \_\_\_\_\_  
\_\_\_\_\_

Please provide any other insights and/or information that you feel might be helpful in your health maintenance: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***As it is always helpful for us to have ample time to review this pertinent information, we request (if possible) all patients send in their paperwork at least one day prior to their scheduled appointment. If accessible, you can send your paperwork to us by scanning and emailing it to [sjkidd31@gmail.com](mailto:sjkidd31@gmail.com).***

# Symptom Questionnaire

(Adapted from Julia Ross's book, "The Diet Cure")

This questionnaire is a quick way to assess many potential root causes of clinical conditions. We use this questionnaire as a springboard to develop a personalized nutrition program and, upon follow-up, to assess improvement.

## Hormones (women only)

\_\_\_\_\_ Total Score

- 4 Premenstrual mood swings
- 4 Premenstrual or menopausal food cravings
- 4 Irregular periods or migraines
- 3 Experienced miscarriage, abortion, or infertility
- 4 Use(d) birth control pills or hormone medication
- 3 Uncomfortable periods - cramps, lengthy or heavy bleeding, sore breasts
- 4 Peri- or postmenopausal discomfort (hot flashes, weight gain, sweats, insomnia, mental dullness)
- 3 Skin eruptions with period

*If your score is over 6, your hormones may be out of balance and you may benefit from salivary hormone testing to determine baseline hormone levels. Well-balanced hormones regulate everything from reproduction to emotions, general health, and well-being.*

## Blood Sugar and Stress

\_\_\_\_\_ Total Score

- 4 Crave a lift from sweets or alcohol, but experience a drop in mood afterwards
- 4 Family history of diabetes, hypoglycemia or alcoholism
- 4 Fatigue after meals
- 3 Nervous, jittery, irritable, headachy or worse, on and off during the day. Calmer after meals.
- 3 Frequent infections, allergies or asthma, especially when the weather changes
- 3 Mental confusion, decreased memory, hard to focus or get organized
- 4 Frequent thirst
- 3 Night sweats (not due to menopause)
- 5 Light-headed, especially upon standing up
- 4 Crave salty foods or licorice
- 4 Often feel stressed, overwhelmed and exhausted
- 4 Dark circles under eyes or eyes sensitive to bright light
- 4 More awake at night

*If your score is over 12, it's important that you work on balancing blood sugar and controlling your stress levels.*

## Thyroid Function

\_\_\_\_\_ Total Score

- 4 Low energy
- 4 Easily chilled (especially hands and feet)
- 4 Other family members have thyroid problems
- 4 Gain weight easily, without overeating; hard to lose excess weight
- 3 Have to force yourself to do even moderate exercise
- 4 Find it hard to get going in the morning
- 3 High cholesterol
- 3 Low blood pressure
- 4 Weight gain began near the start of menses, pregnancy, menopause or after traumatic event
- 3 Chronic headaches
- 3 Loss of outer third portion of eyebrows
- 3 Depression, loss of vitality
- 3 Use food, caffeine, tobacco and/or other stimulants to get going

*If your score is over 15, you may need to get your thyroid checked. There are many ways nutritionally to support your thyroid, for more energy, naturally.*

## Food Allergies

\_\_\_\_\_ Total Score

- 3 Crave milk, ice cream, yogurt, or cheese or doughy foods and eat them frequently
- 3 Experience bloating after meals

- 4 Gas, frequent belching
- 3 Digestive discomfort of any kind
- 3 Chronic constipation and/or diarrhea
- 4 Respiratory problems, such as asthma, postnasal drip, congestion
- 3 Low energy or drowsiness, especially after meals
- 4 Allergic to milk products or other common foods
- 3 Under-eat or often prefer beverages to solid foods
- 3 Avoid food or throw up food because bloating after eating makes you feel fat or tired
- 4 Can't gain weight
- 3 Hyperactivity or depression
- 3 Severe headaches or migraine
- 4 Food allergies in the family

*If your score is over 12, you may be craving foods you are allergic to. Elimination diets can pinpoint the offending foods, and elimination of them usually results in weight loss and increased energy.*

**Antinutrient Load** \_\_\_\_\_ **Total Score**

- 1 Drink tap water majority of the time
- 1 More than half the food you eat is not organic
- 1 Spend an hour or more a day in traffic
- 1 Live in a city
- 1 Smoke, or live or work with smokers
- 1 Eat fried foods often
- 1 Eat nonorganic meat or fish or large fish like tuna or swordfish
- 1 Take more than twenty painkillers in a year
- 1 Take, on average, one course of antibiotics each year
- 1 Most of the food you eat or drink is in contact with soft plastic or cling wrap
- 1 Consume an alcoholic drink on most days

*The ideal score is 0. A score of 5 or more means you are likely to be taking in a significant quantity of antinutrients. Any yes answer highlights areas in your diet and lifestyle that warrant attention.*

**Yeast** \_\_\_\_\_ **Total Score**

- 4 Often bloated; abdominal extension
- 3 Foggy-headed
- 2 Depressed
- 4 Recurrent yeast infections
- 4 Used antibiotics extensively (any point in life)
- 4 Used cortisone or birth control pills for more than one year
- 4 Have chronic fungus on nails or skin; athlete's foot
- 3 Recurring sinus or ear infections as an adult or child
- 3 Achy muscles and joints
- 4 Rashes
- 3 Stool unusual in color, shape or consistency

*If your score is over 12, you most likely have yeast overgrowth which can be addressed through dietary changes and nutritional therapies.*

**Low Calorie Dieting** \_\_\_\_\_ **Total Score**

- 4 Increased cravings for and focus on food, overeating
- 4 Regain weight after dieting, more than was lost
- 3 Increased moodiness, irritability, anxiety or depression
- 3 Less energy and endurance
- 3 Usually eat less than 2,100 calories/day
- 3 Skip meals, especially breakfast
- 3 Eat mostly low-fat carbs like bagels and pasta
- 2 Constantly think about weight
- 2 Use aspartame daily
- 2 Take Prozac or similar serotonin-boosting drugs
- 2 Have become vegetarian
- 3 Decreased self-esteem

4 Have become bulimic or anorexic

*If your score is over 12, your body may not be burning calories as fast as it could and should, due to low calorie intake. You may also be deficient in critical nutrients. Through counseling, you will learn why it's important NOT to deprive yourself of food.*