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:

____

Are you currently pregnant? Y N If yes, when is your estimated due date?___________________

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:

____ ____
____ ____
____ ____
____ ____

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
____Alcoholic
____Allergies
____Alopecia
____Anemia
____Antibiotic use (extended)
____Anxiety
____Autoimmune disease
____Bloating/gas
____Candida Albicans
____Celiac disease
____Chron's Disease
____Colds/flu
____Constipation
____Depression
____Diarrhea
____Diverticulosis
____Drug Addictions
____Dry skin
____Dry hair
____Eczema
____Endometriosis
____Excessive fatigue
____Facial hair growth
____Fainting/dizzy spells
____Feel hot often
____Feel cold often
____Fibroids
____Gastritis
____Hair loss/thinning
____Headaches
____Heartburn/reflux
____Hemorrhoids
____Herpes
____High Cholesterol
____High Blood Pressure
____Hot Flashes
____Hypoglycemic
____Hypothyroid
____Hyperthyroid
____Insomnia
____Irregular menses
____Irritable Bowel Syndrome
____Irritable/depressed during menses
____Leg/muscle cramps
____Less than 1 bowel movement per day
____Liver Disease
____Low Blood Pressure
____Low Cholesterol
____Low libido
____Lupus
____Menstrual clotting
____Menstrual cramps
____Migraines
____Multiple Sclerosis
____Nausea
____Nervous breakdown
____Nervousness
____Numbness
____Polycystic Ovarian Syndrome
____Rheumatoid arthritis
____Sciatica
____Skin ulcers
____STD
____Thyroid disease
____Ulcerative Colitis
____Unexplained Weight Gain
____Yeast Infections (chronic)

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?______________________________

Menopause?__________ Age at menopause: _______ Symptoms: ____

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

Men:

Do you get up during the night to urinate?____________ If yes, how often? _________________

Are you having any problems getting or maintaining an erection?_________

Please rate your current sexual libido on a scale of 1-10 (10 being the best) __________

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___ Eat daily___ Eat several times weekly_____ Rarely___ None___

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

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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.

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.