

**Men's Nutrition Intake**

File #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Gender: M / F / Other Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: A / AB / B / O Rh: + / -

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

**Purpose of Appointment:** (What are you hoping to gain from this experience?)  
\_\_\_\_\_  
\_\_\_\_\_**Health Conditions and Complaints:** (list in order of severity)

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Medical Diagnosis:**

Diagnosis	Date of Onset	Past or Current (circle)
		Past / Current
		Past / Current
		Past / Current

What types of therapies have you tried for these problems or to improve your overall health (circle all that apply)?

Diet Modification / Fasting / Vitamins and Minerals / Herbs / Homeopathy / Chiropractic / Acupuncture /  
Conventional Drugs / Other: \_\_\_\_\_

Do you experience any of these general symptoms EVERY DAY (circle all that apply)?

Debilitating Fatigue / Depression / Decreased Libido / Disinterest in Eating / Shortness of Breath / Panic Attacks /  
Headaches / Dizziness / Insomnia / Nausea / Vomiting / Diarrhea / Constipation / Fecal Incontinence / Urinary  
Incontinence / Low Grade Fever / Chronic Pain or Inflammation / Bleeding / Discharge / Itching or Rash

Have you ever taken antibiotics: Y / N If yes, when was your last course: \_\_\_\_\_

Have you ever been on hormone replacement therapy: Y / N If yes: Current or Past

**Current Medications and Supplements:**

Name	Dosage	Frequency	Duration

**Allergies:** \_\_\_\_\_

My signature confirms that this information of complete and true to the best of my knowledge.

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Legal Guardian Print: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Procedures, Hospitalizations, Injuries, Serious Illness:**

Date	Procedure/Surgery/Illness	Outcome	Physician

Date of Last Physical: \_\_\_\_\_ Results: \_\_\_\_\_

Date of Last Lab Test: \_\_\_\_\_ Results: \_\_\_\_\_

Date of Last PSA/Prostate Test: \_\_\_\_\_ Results: \_\_\_\_\_

Rate your current level of stress (1 – lowest 10 – highest) 1 – 2 – 3 – 4 – 4 – 6 – 7 – 8 – 9 - 10

Main Stressors: \_\_\_\_\_

How do you reduce stress? \_\_\_\_\_

Have you had any unintentional weight loss or gain of 10 pounds or more in the last three months? Y / N

**What would you like to accomplish (circle those that apply):**

Vitality	Body Composition	Stress, Mental, Emotional	Life Enrichment
Feel More Vital	Lose Weight	Learn How to Reduce Stress	Reduce Risk of Degen. Disease
Have More Energy	Burn More Body Fat	Think Clearly and Be Focused	Slow Down Accelerated Aging
Have More Endurance	Be Stronger	Improve Memory	Maintain a Healthier Life
Be Less Tired After Lunch	Increase Muscle Tone	Be Less Depressed	Create a Wellness Lifestyle
Sleep Better	Increase Flexibility	Be Less Moody	
Be Free of Pain		Be Less Indecisive	
Get Less Colds and Flu		Feel More Motivated	
Get Rid of Allergies			
Limit OTC Medication			
Stop Laxatives/Stool Softeners			
Improve Sex Drive			

My signature confirms that this information of complete and true to the best of my knowledge.

Patient/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient/Legal Guardian Print: \_\_\_\_\_

Date: \_\_\_\_\_

**Medical History** (circle those that apply):

- |                          |                                       |                              |
|--------------------------|---------------------------------------|------------------------------|
| Arthritis                | Eating Disorder                       | Mental Illness               |
| Allergies/Hay Fever      | Epilepsy                              | Mental Retardation           |
| Asthma                   | Emphysema                             | Migraine Headaches           |
| Alcoholism               | Ear, Nose, Eye, Throat Problems       | Neurological Problems        |
| Alzheimer's Disease      | Environmental Sensitivities           | Sinus Problems               |
| Autoimmune Disease       | Fibromyalgia                          | Stroke                       |
| Blood Pressure Problems  | Food Intolerance                      | Thyroid Trouble              |
| Bronchitis               | Gastroesophageal Reflux Disease       | Obesity                      |
| Cancer                   | Genetic Disorder                      | Osteoporosis                 |
| Chronic Fatigue Syndrome | Glaucoma                              | Pneumonia                    |
| Cholesterol, elevated    | Gout                                  | Sexually Transmitted Disease |
| Circulatory Problems     | Heart Disease                         | Seasonal Affective Disorder  |
| Colitis                  | Infection, chronic                    | Skin Problems                |
| Dental Problems          | Inflammatory Bowel Disease            | Tuberculosis                 |
| Depression               | Irritable Bowel Syndrome              | Ulcer                        |
| Diabetes                 | Kidney or Bladder Disease             | Urinary Tract Infection      |
| Diverticular Disease     | Learning Disabilities                 | Varicose Veins               |
| Drug Addiction           | Liver or Gallbladder Disease (Stones) | Other: _____                 |

**Reproductive Health** (circle those that apply):

- |                              |                  |                               |
|------------------------------|------------------|-------------------------------|
| Benign Prostatic Hyperplasia | Decreased Libido | Sexually Transmitted Diseases |
| Prostate Cancer              | Infertility      | Other: _____                  |

**Family Health History** (circle all that apply):

- |                     |                       |                        |
|---------------------|-----------------------|------------------------|
| Arthritis           | Eating Disorder       | Neurological Disorders |
| Asthma              | Glaucoma              | Obesity                |
| Alcoholism          | Heart Disease         | Osteoporosis           |
| Alzheimer's Disease | Infertility           | Stroke                 |
| Cancer              | Learning Disabilities | Suicide                |
| Depression          | Mental Illness        | Other: _____           |
| Diabetes            | Mental Retardation    |                        |
| Drug Addiction      | Migraine Headaches    |                        |

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Lifestyle and Health Overview:**

Do you follow any specific plan of eating? Y/ N Describe: \_\_\_\_\_

Identify your eating style: 1 Meal Daily / 2 Meals Daily / 3 Meals Daily / Graze / Eat on the Run / Eat Constantly

How often do you eat the following daily:

Fruits: \_\_\_\_\_ Beans, Peas, Legumes: \_\_\_\_\_

Dark Green Vegetables: \_\_\_\_\_ Dairy, Eggs: \_\_\_\_\_

Deep Yellow/Orange Vegetables: \_\_\_\_\_ Meat, Poultry, Fish: \_\_\_\_\_

Grains (unprocessed): \_\_\_\_\_

Digestion: Good / Adequate / Poor Symptoms: Acid Reflux / Burping / Bloating / Burning / Pain / Cramping / NA

Bowels Movements: Daily \_\_\_\_\_ Weekly: \_\_\_\_\_ Consistency: Normal / Hard / Soft / Diarrhea

Urination: Normal / Too Frequent / Sense of Urgency / Burning / Dribbling / Loss of Control / Wake at Night

Additional Complaints: \_\_\_\_\_

Do you drink water: Y / N How much water do you drink daily? \_\_\_\_\_

Mark which you drink and how many a day (d) or week (w) you drink them:

Milk: \_\_\_\_\_ Herbal Tea: \_\_\_\_\_ Wine: \_\_\_\_\_

Coffee: \_\_\_\_\_ Soda: \_\_\_\_\_ Liquor: \_\_\_\_\_

Tea: \_\_\_\_\_ Beer: \_\_\_\_\_ Other: \_\_\_\_\_

What are your exercise habits:

Frequency: 5-7 Days / 3-4 Days / 1-2 Days Duration: 45+ min. / 30-45 min. / Less than 30 min.

Type of Exercise: Walking / Running / Aerobics / Weight Lifting / Cross Fit / Yoga / Pilates / Other: \_\_\_\_\_

Sleep: Restful / Restless / Hard to fall asleep / Wake Often / Wake to urinate / Nightmares / Night Terrors

What time do you go to sleep? \_\_\_\_\_ Number of hours of sleep per night? \_\_\_\_\_

Do you smoke? Y / N If yes, how many cigarettes/cigars and often? \_\_\_\_\_

**Drug Use (CONFIDENTIAL):**

Recreational Drug Use: Y/N If yes: Marijuana / Cocaine / Heroin / Uppers / Downers / Other: \_\_\_\_\_

How often? \_\_\_\_\_ How long? \_\_\_\_\_

Remember to list any supplements or medications on the first page.

My signature confirms that this information of complete and true to the best of my knowledge.

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Legal Guardian Print: \_\_\_\_\_ Date: \_\_\_\_\_

## Toxicity Questionnaire

Please circle a number in each of the following categories based on your health in the last 30 days.

**0**=Rarely/never experience the symptom **1**=Occasionally experience but effect is not severe  
**2**=Occasionally experience but effect is severe **3**=Frequently experience and effect is not severe  
**4**=Frequently experience and effect is severe

<p><b>Digestive:</b></p> <p>Gas, Belch, Bloating      0 1 2 3 4</p> <p>Heartburn, Reflux        0 1 2 3 4</p> <p>Nausea                      0 1 2 3 4</p> <p>Strain on bowel mvmt    0 1 2 3 4</p> <p>Day w/o bowel mvmt    0 1 2 3 4</p> <p>Diarrhea, Vomiting      0 1 2 3 4</p> <p>Hemorrhoids              0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p>	<p><b>Hormones:</b></p> <p>Oily skin, Acne            0 1 2 3 4</p> <p>Pain during period        0 1 2 3 4</p> <p>Breast tenderness        0 1 2 3 4</p> <p>Irregular Cycle          0 1 2 3 4</p> <p>Weight Gain               0 1 2 3 4</p> <p>Cry easily                  0 1 2 3 4</p> <p>Vaginal dryness          0 1 2 3 4</p> <p>Hot flashes                0 1 2 3 4</p> <p>Loss of sex drive         0 1 2 3 4</p> <p>Erectile dysfunction     0 1 2 3 4</p> <p>Balding                    0 1 2 3 4</p> <p>Anger easily               0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p> <p><b>Head, Eyes:</b></p> <p>Blurred vision            0 1 2 3 4</p> <p>Pressure head/eyes      0 1 2 3 4</p> <p>Faintness                 0 1 2 3 4</p> <p>Dizziness                 0 1 2 3 4</p> <p>Headaches                0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p> <p><b>Allergies:</b></p> <p>Watery, Itchy Eyes      0 1 2 3 4</p> <p>Runny nose                0 1 2 3 4</p> <p>Sneezing                  0 1 2 3 4</p> <p>Itchy throat               0 1 2 3 4</p> <p>Itchy skin                 0 1 2 3 4</p> <p>Post nasal drip          0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p> <p><b>Immune:</b></p> <p>Frequent illness         0 1 2 3 4</p> <p>Sore throat                0 1 2 3 4</p> <p>Fever                       0 1 2 3 4</p> <p>Genital itch, Discharge 0 1 2 3 4</p> <p>Yellow nail fungus      0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p>	<p><b>Ears, Sinus, Nose:</b></p> <p>Popping ears              0 1 2 3 4</p> <p>Fluid in ears              0 1 2 3 4</p> <p>Ringing ear, Hearing loss 0 1 2 3 4</p> <p>Earaches, Infections    0 1 2 3 4</p> <p>Excessive mucous        0 1 2 3 4</p> <p>Stuffy Nose               0 1 2 3 4</p> <p>Sinus Headache          0 1 2 3 4</p> <p>Nose bleeds               0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p> <p><b>Mouth, Throat, Teeth:</b></p> <p>Dry mouth                 0 1 2 3 4</p> <p>Canker sores              0 1 2 3 4</p> <p>Tooth pain                0 1 2 3 4</p> <p>Bleeding gums            0 1 2 3 4</p> <p>Gagging, Clearing throat 0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p> <p><b>Lungs:</b></p> <p>Difficulty breathing     0 1 2 3 4</p> <p>Chest congestion        0 1 2 3 4</p> <p>Coughing                 0 1 2 3 4</p> <p>Asthma                    0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p> <p><b>Joints, Muscle, Bone:</b></p> <p>Twitching                 0 1 2 3 4</p> <p>Cramping                 0 1 2 3 4</p> <p>Stiff and achy joints    0 1 2 3 4</p> <p>Pain in joints             0 1 2 3 4</p> <p>Muscle ache              0 1 2 3 4</p> <p>Muscle pain              0 1 2 3 4</p> <p>Osteoporosis             0 1 2 3 4</p> <p>Numbness, Burning      0 1 2 3 4</p> <p>Flat feet, Fallen arch    0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p> <p><b>Sleep:</b></p> <p>Inability to fall asleep 0 1 2 3 4</p> <p>Wake up often            0 1 2 3 4</p> <p>Nighttime urination     0 1 2 3 4</p> <p>Wake up tired            0 1 2 3 4</p> <p>Bad Dreams, Nightmares 0 1 2 3 4</p> <p>Night sweats             0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p>
<p><b>Heart:</b></p> <p>Shortness of breath      0 1 2 3 4</p> <p>Tightness in chest       0 1 2 3 4</p> <p>Chest pain                0 1 2 3 4</p> <p>Rapid, Skipped heartbeat 0 1 2 3 4</p> <p>High, Low Blood Pressure 0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p> <p><b>Emotions:</b></p> <p>Mood swings              0 1 2 3 4</p> <p>Anger, Irritability       0 1 2 3 4</p> <p>Anxious, Fearful, Nervous 0 1 2 3 4</p> <p>Panic attacks             0 1 2 3 4</p> <p>Sense of Despair         0 1 2 3 4</p> <p>Depression                0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p> <p><b>Energy:</b></p> <p>Restlessness              0 1 2 3 4</p> <p>Hyperactivity             0 1 2 3 4</p> <p>Brain fog                 0 1 2 3 4</p> <p>Sluggishness              0 1 2 3 4</p> <p>Fatigue, Tired            0 1 2 3 4</p> <p>Swelling hands and feet 0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p> <p><b>Skin, Hair, Nails:</b></p> <p>Flushing                  0 1 2 3 4</p> <p>Cold hands and feet      0 1 2 3 4</p> <p>Acne                        0 1 2 3 4</p> <p>Dry skin / Oily skin      0 1 2 3 4</p> <p>Hives, Rashes            0 1 2 3 4</p> <p>Eczema, Psoriasis        0 1 2 3 4</p> <p>Hair loss                  0 1 2 3 4</p> <p>Cracked heels on feet    0 1 2 3 4</p> <p>Bruising                  0 1 2 3 4</p> <p>Brittle nails              0 1 2 3 4</p> <p style="text-align: right;"><b>Total for section:</b> _____</p>	<p style="text-align: right;"><b>Total for section:</b> _____</p>	<p style="text-align: right;"><b>Total for section:</b> _____</p>

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**TOTAL FOR PAGE =** \_\_\_\_\_