Women'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. _____________________________
2. _____________________________
3. _____________________________
4. _____________________________
5. _____________________________
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 OB/GYN Exam: __________ Date of Last Mammogram/Thermogram: ______________________

Date of Last Pap smear: _______________ Results: + / - Pregnant: Yes / No / Maybe

Using Birth Control: Y / N What Form: _______________ Menopausal: Y / N Surgical Menopause: Y / N

Number of Pregnancies: ________ Number of Live Births: ________ Number of children: ________

Delivery: Natural / C-section / Other: ___________

First Period (age): ________ Last Menstrual Cycle: ________ Length of Cycle: ________ Time Between Cycles: ______

Flow: Spotting / Light / Heavy / Large Clots Color: Bright Red / Deep Red / Brown / Black

Symptoms: Cramping / Headaches / Body Aches / Nausea / Vomiting / Fatigue

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):

Menstrual Irregularities	Fibrocystic Breasts	Pelvic Inflammatory Disease
Endometriosis	Fibroids/Ovarian Cysts	Decreased Libido
Infertility	Premenstrual Syndrome	Sexually Transmitted Disease
Vaginal Infections	Breast Cancer	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: ___________

Dark Green Vegetables: ___________

Deep Yellow/Orange Vegetables: ___________

Grains (unprocessed): ___________

Beans, Peas, Legumes: ___________

Dairy, Eggs: ___________

Meat, Poultry, Fish: ___________

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: ________

Coffee: ________

Tea: ________

Herbal Tea: ________

Soda: ________

Beer: ________

Wine: ________

Liquor: ________

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

Digestive:

Gas, Belch, Bloating	0 1 2 3 4
Heartburn, Reflux	0 1 2 3 4
Nausea	0 1 2 3 4
Strain on bowel mvmt	0 1 2 3 4
Day w/o bowel mvmt	0 1 2 3 4
Diarrhea, Vomiting	0 1 2 3 4
Hemorrhoids	0 1 2 3 4
Total for section:	______

Heart:

Shortness of breath	0 1 2 3 4
Tightness in chest	0 1 2 3 4
Chest pain	0 1 2 3 4
Rapid, Skipped heartbeat	0 1 2 3 4
High, Low Blood Pressure	0 1 2 3 4
Total for section:	______

Emotions:

Mood swings	0 1 2 3 4
Anger, Irritability	0 1 2 3 4
Anxious, Fearful, Nervous	0 1 2 3 4
Panic attacks	0 1 2 3 4
Sense of Despair	0 1 2 3 4
Depression	0 1 2 3 4
Total for section:	______

Energy:

Restlessness	0 1 2 3 4
Hyperactivity	0 1 2 3 4
Brain fog	0 1 2 3 4
Sluggishness	0 1 2 3 4
Fatigue, Tired	0 1 2 3 4
Swelling hands and feet	0 1 2 3 4
Total for section:	______

Skin, Hair, Nails:

Flushing	0 1 2 3 4
Cold hands and feet	0 1 2 3 4
Acne	0 1 2 3 4
Dry skin / Oily skin	0 1 2 3 4
Hives, Rashes	0 1 2 3 4
Eczema, Psoriasis	0 1 2 3 4
Hair loss	0 1 2 3 4
Cracked heels on feet	0 1 2 3 4
Bruising	0 1 2 3 4
Brittle nails	0 1 2 3 4
Total for section:	______

Hormones:

Oily skin, Acne	0 1 2 3 4
Pain during period	0 1 2 3 4
Breast tenderness	0 1 2 3 4
Irregular Cycle	0 1 2 3 4
Weight Gain	0 1 2 3 4
Cry easily	0 1 2 3 4
Vaginal dryness	0 1 2 3 4
Hot flashes	0 1 2 3 4
Loss of sex drive	0 1 2 3 4
Erectile dysfunction	0 1 2 3 4
Balding	0 1 2 3 4
Anger easily	0 1 2 3 4
Total for section:	______

Head, Eyes:

Blurred vision	0 1 2 3 4
Pressure head/eyes	0 1 2 3 4
Faintness	0 1 2 3 4
Dizziness	0 1 2 3 4
Headaches	0 1 2 3 4
Total for section:	______

Allergies:

Watery, Itchy Eyes	0 1 2 3 4
Runny nose	0 1 2 3 4
Sneezing	0 1 2 3 4
Itchy throat	0 1 2 3 4
Itchy skin	0 1 2 3 4
Post nasal drip	0 1 2 3 4
Total for section:	______

Immune:

Frequent illness	0 1 2 3 4
Sore throat	0 1 2 3 4
Fever	0 1 2 3 4
Genital itch, Discharge	0 1 2 3 4
Yellow nail fungus	0 1 2 3 4
Total for section:	______

Urinary Tract:

Frequent urination	0 1 2 3 4
Burning on urination	0 1 2 3 4
Dribbling urine	0 1 2 3 4
Leaky bladder	0 1 2 3 4
Blood in urine	0 1 2 3 4
Kidney stones	0 1 2 3 4
Total for section:	______

Ears, Sinus, Nose:

Popping ears	0 1 2 3 4
Fluid in ears	0 1 2 3 4
Ringing ear, Hearing loss	0 1 2 3 4
Earaches, Infections	0 1 2 3 4
Excessive mucous	0 1 2 3 4
Stuffy Nose	0 1 2 3 4
Sinus Headache	0 1 2 3 4
Nose bleeds	0 1 2 3 4
Total for section:	______

Mouth, Throat, Teeth:

Dry mouth	0 1 2 3 4
Canker sores	0 1 2 3 4
Tooth pain	0 1 2 3 4
Bleeding gums	0 1 2 3 4
Gagging, Clearing throat	0 1 2 3 4
Total for section:	______

Lungs:

Difficulty breathing	0 1 2 3 4
Chest congestion	0 1 2 3 4
Coughing	0 1 2 3 4
Asthma	0 1 2 3 4
Total for section:	______

Joints, Muscle, Bone:

Twitching	0 1 2 3 4
Cramping	0 1 2 3 4
Stiff and achy joints	0 1 2 3 4
Pain in joints	0 1 2 3 4
Muscle ache	0 1 2 3 4
Muscle pain	0 1 2 3 4
Osteoporosis	0 1 2 3 4
Numbness, Burning	0 1 2 3 4
Flat feet, Fallen arch	0 1 2 3 4
Total for section:	______

Sleep:

Inability to fall asleep	0 1 2 3 4
Wake up often	0 1 2 3 4
Nighttime urination	0 1 2 3 4
Wake up tired	0 1 2 3 4
Bad Dreams, Nightmares	0 1 2 3 4
Night sweats	0 1 2 3 4
Total for section:	______

Name: ____________________________________ Date: _________________ **TOTAL FOR PAGE =** __________