A BALANCED APPROACH nutrition

NUTRITIONAL ASSESSMENT

Name:_____ **Email:** _____
Today's date: _____ **Birthdate / age:** _____**Phone:**_____
Address:_____ **City:**_____ **Zip:**_____
Marital Status: ☐ **M** ☐ **D** ☐ **S** ☐ **W**
Employer_____ **Occupation:**_____
Emergency Contact:_____ **Relation:**_____ **Phone:**_____
Main reason for nutritional consultation: _____
_____
List medications / supplements: _____
_____
_____
Allergies (food / medications) _____
Past medical history (dates)
Surgeries:_____
_____
Serious illnesses: _____
Fractures / Traumas:_____

Dietary Patterns:

As an infant were you: ☐ Breastfed _____ # of months. ☐ Bottle fed: _____ Formula type
Childhood diet: ☐ American ☐ Vegetarian ☐ Specialty diet _____
Adult diet: ☐ American ☐ Vegetarian ☐ Gluten Free ☐ Dairy Free ☐ Other _____
Have you used weight loss diets in the past? Yes ☐ No ☐ Type _____
How many meals to you eat per day? _____ Percent of meals eaten at home _____%
Do you use a microwave? Yes ☐ No ☐ Percent of organic / locally grown food _____%
What type of salt do you use?_____sweetener?_____

Weight History:

Have you gained or lost weight recently? Yes ☐ No ☐ Amount gained ___ Amount lost_____
Current weight _____ lbs. Height ___ft ____inches **Weight / BF% per office scale:**_____
What do you consider an ideal weight for yourself? _____lbs.
Any history of eating disorders? ☐ Yes ☐ No Specific cravings?_____

Exercise:

Do you exercise on a consistent basis? ☐ Yes ☐ No
Check all that apply: ☐ Aerobics ☐ Weights ☐ Cycling ☐ Elliptical ☐ Running / Jogging

☐ Walking ☐ Swimming ☐ Team sports ☐ Other:_____

What is your greatest obstacle to exercising?_____

Beverages:

Type of water: ☐ City ☐ Bottled ☐ Reverse Osmosis ☐ Well ☐ Other_____

Amount of water per day: _____ cups / 8 oz servings

Sodas_____ per day Coffee / Tea _____ per day Herbal / Decaf _____per day

Beer _____ per day Wine: ☐White ☐Red _____per day Liquor _____(oz) per day

Head / Neck:

Headaches ☐ Yes ☐ No If yes, list contributing factors:_____

Dental problems, bleeding gums, or gingivitis ☐ Yes ☐ No

Any constant coating on tongue? ☐ Yes ☐ No If yes color_____

Is your tongue sore or bright red? ☐ Yes ☐ No Hair falling out? ☐ Yes ☐ No0

Allergies / Post nasal drip ☐ Yes ☐ No Type:_____

Frequent colds / sinus infections ☐ Yes ☐ No

Blurred vision: ☐ Yes ☐ No Night Blindness ☐ Yes ☐ No Flashing lights ☐ Yes ☐ No

Tinnitus / Noises in the ear ☐ Yes ☐ No Dizziness ☐ Yes ☐ No

Cardiovascular / Lungs:

History of heart attack / angina ☐ Yes ☐ No High cholesterol ☐ Yes ☐ No

Elevated blood pressure ☐ Yes ☐ No Current reading _____

History of facial drooping or weakness on one side of body? ☐ Yes ☐ No

Swelling of the feet / ankles ☐ Yes ☐ No Heart Pounds / Skip Beats ☐ Yes ☐ No

Cramps in legs / feet after walking, exercising or at night ☐ Yes ☐ No

Do you smoke or use tobacco products / marijuana ☐ Yes ☐ No If yes duration_____

Shortness of Breath ☐ Yes ☐ No Bronchitis / Pneumonia ☐Yes ☐ No

Asthma ☐ Yes ☐ No COPD ☐ Yes ☐ No Have you been on steroid inhalers? ☐Yes ☐No

Digestion:

Check all that apply:

Bloating ☐ Acid Reflux / Heartburn ☐ Abdominal Pain ☐ Excessive Gas ☐

Bowel movements: frequency ☐ < 1 per day ☐ daily ☐ 2-3 per day ☐ + 3 per day

Consistency of bowel movements: ☐Loose ☐Normal ☐Hard ☐Combination

Hemorrhoids ☐ Yes ☐ No Anemia ☐ Yes ☐ No Blood in stool: ☐ Yes ☐ No

Do you take laxatives or fiber on a consistency basis? ☐ Yes ☐ No

History of Inflammatory Bowel Disease? ☐ Yes ☐ No

Have you ever had a bowel resection? ☐ Yes ☐ No Reason: _____

Are you currently taking anti-acid medications? ☐ Yes ☐ No If yes, how long? _____

Musculoskeletal:

Joint Pain: ☐ Yes ☐ No If yes, location / duration:_____

Arthritis ☐ Yes ☐ No type:_____ Gout: ☐ Yes ☐ No

Scoliosis ☐ Foot trouble ☐ Tendonitis ☐ Degenerative Disc Disease ☐

Are you under the care of a chiropractor ☐ Yes ☐ No Name of D.C._____

Condition of Nails: ☐ Brittle ☐ Curved ☐ White spots ☐ Ridged

Numbness / tingling in legs or arms ☐ Yes ☐ No

Have you been diagnosed with osteopenia / osteoporosis? ☐ Yes ☐ No

Date of last Dexascan: _____

Endocrine / Sleep:

Are you a diabetic? ☐ Yes ☐ No If yes at what age _____

Insulin dependent: ☐ Yes ☐ No Oral anti-diabetic meds, list _____

Thyroid disorders: ☐ Yes ☐ No If yes type / meds _____

How many hours of sleep do you average per night? _____

Insomnia ☐ Yes ☐ No If yes, explain_____ Sleep Apnea? ☐ Yes ☐ No

Do you feel chronically fatigued? ☐ Yes ☐ No

Brain Health:

Brain fog: ☐ Yes ☐ No Forgetfulness: ☐ Yes ☐ No Anxiety: ☐ Yes ☐ No

Significant memory loss: ☐ Yes ☐ No Panic Attacks ☐ Yes ☐No

Hyperactivity: ☐ Yes ☐ No Seizures (ever): ☐ Yes ☐ No

ANY head trauma: (list, dates)_____ Hx of Alzheimer's in family ☐ Yes ☐ No

Environmental Toxins:

Do you use antibacterial soaps**?** ☐ Yes ☐No Do you wear perfume or cologne? ☐Yes ☐ No

What percent of your household cleaners are natural, "green"? _____%

Is your lawn / garden treated regularly with fertilizers / herbicides / pesticides? ☐Yes ☐ No

Have you been exposed to a moldy environment for an extended period of time? ☐ Yes ☐ No

Do you have mercury amalgams in your teeth? ☐Yes ☐ No

Work place exposure to industrial chemicals, toxins or heavy metals? ☐ Yes ☐ No

Do you have symptoms of multiple chemical sensitivities? ☐ Yes ☐ No

Do you regularly get a flu shot? ☐Yes ☐ No Have you had a vaccine reaction? ☐Yes ☐ No

Women:

Menstrual history: Cycle regular: ☐ Yes ☐ No Average length (days) _____

Is the flow ☐ Heavy ☐ Medium ☐ Light PMS / Cramping: ☐ Yes ☐ No

Number of pregnancies _____Vaginal ____ C-sections_____Miscarriages:_____

Have you been diagnosed with polycystic ovarian syndrome (PCOS)? ☐ Yes ☐ No

Have you been treated for infertility? ☐ Yes ☐ No

Age at menopause: _____ Taking hormone replacement? ☐ Yes ☐ No

Do you have hot flashes / night sweats: ☐ Yes ☐ No If yes how frequent: _____

History of yeast infections ☐ Yes ☐ No UTI's ☐ Yes ☐ No

Any urinary incontinence: ☐ Yes ☐ No Describe:_____

Men:

History of prostate problems: ☐ Yes ☐ No Last PSA:_____

Any urinary frequency / dribbling: ☐ Yes ☐ No Night time voiding > 1x ☐ Yes ☐ No

Weak stream: ☐ Yes ☐ No Problems with ED: ☐ Yes ☐ No

Have you been evaluated for infertility? ☐ Yes ☐ No

Family History / General:

List any significant health issues that run in your family: _____

_____

List your goals that you would like to accomplish through nutritional counseling:

1).____

2).____

3).____

How would you prefer nutritional assessment / counseling be guided? (check all that apply)

☐ Dietary review, recommendations for healthy choices, general supplements

☐ Extensive coaching, weight checks on a scheduled basis; accountability

☐ Supplement recommendations for specific health conditions, includes muscle testing.

☐ General blood work analysis, including vitamin D / B 12

☐ Body chemistry analysis for targeted health conditions (hair / stool analysis, hormone salivary panels, etc)

☐ Genetic testing, includes detailed report on multiple health concerns and recommendations for diet / exercise and supplements.

What percent are you committed to getting well and staying well?_____%

The statements made on this form are accurate to the best of my recollections:

_____ _____

(*Signature*) **(*Date*)**