ABA Chiropractic Holistic Health Center
Nutritional Assessment

Name:______________________________ **DOB:**_________ **Age:** _____________
Social Security #____________________ **Marital Status:** ☐ **M** ☐ **D** ☐ **S** ☐ **W**
Employer_________________________ **Occupation:**_________________________
Address:_________________________________ **City:**____________ **Zip:**_________
Phone:_____________ **Alternate phone:**______________ **Today's date:**________
Emergency Contact:_________________ **Relation:**___________ **Phone:**________

Main reason for nutritional consultation: _________________________________
____

List all medications: ____
____

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 ________%

Current Supplements: ____
____
____

Weight History:

Have you gained or lost weight recently? Yes ☐ No ☐ Amount gained ___ Amount lost_____

Current weight ______ lbs. Height ___ft ____inches

What do you consider an ideal weight for yourself? ________lbs.

Any history of eating disorders? ☐ Yes ☐ No

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 what duration or contributing factors (food, hormonal, etc.)

____

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

Cramps in leg muscles after walking long distance or exercising ☐ Yes ☐ No

Do you smoke or have you smoked in the past ☐ Yes ☐ No If yes duration______________

Asthma ☐ Yes ☐ No   Emphysema ☐ Yes ☐ No   Chronic Bronchitis ☐Yes ☐ No

Digestion:

Check all that apply:

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

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

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

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

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

Do you feel chronically fatigued? ☐ 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*)**