
NUTRITIONAL HEALTH HISTORY

Welcome! Please assist us in getting a comprehensive understanding of your current health / nutrition status by filling in the following form.

Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Email: _____ Preferred way to be contacted? _____

Occupation: _____ Family (circle): single / married / significant other / children

Main health concern(s): _____

Do you participate in regular exercise? if so, what and how often? _____

Do you take any medications regularly? (please list, both prescribed and OTC medications): _____

Do you take any supplements / vitamins / herbs currently? (please list): _____

What are your favorite foods? _____

If you have food cravings, what do you normally crave? _____

Any known food allergies or intolerances? _____

Any self-imposed dietary restrictions? (i.e. vegetarian, dislikes, kosher / halal, etc.) _____

Who is your primary care physician? _____

Would you like your PCP to receive a summary of the recommendations you receive today? _____

Please check off any health issues you have experienced recently or chronically from the following list:

- | | | |
|---|--|--|
| <input type="radio"/> acne | <input type="radio"/> food sensitivities | <input type="radio"/> mitral valve prolapse |
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> gastric reflux | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> anemia | <input type="radio"/> gastritis | <input type="radio"/> muscle aches |
| <input type="radio"/> arthritis / inflammation | <input type="radio"/> hay fever | <input type="radio"/> nasal congestion |
| <input type="radio"/> asthma | <input type="radio"/> headaches | <input type="radio"/> numbness and tingling |
| <input type="radio"/> bad breath | <input type="checkbox"/> heartburn | <input type="radio"/> overeating |
| <input type="radio"/> bladder infections | <input type="checkbox"/> heart disease | <input type="radio"/> PMS |
| <input type="checkbox"/> bleeding / bruising | <input type="checkbox"/> herpes | <input type="checkbox"/> pneumonia |
| <input type="radio"/> blisters | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> polio |
| <input type="radio"/> bloating | <input type="checkbox"/> hypoglycemia | <input type="radio"/> poor circulation |
| <input type="checkbox"/> body image issues | <input type="checkbox"/> hepatitis | <input type="radio"/> postnasal drip |
| <input type="radio"/> burning in eyes | <input type="checkbox"/> high cholesterol (_____) | <input type="radio"/> prostatitis |
| <input type="radio"/> burping / flatulence / gas pain | <input type="checkbox"/> high blood pressure (____/____) | <input type="radio"/> psoriasis |
| <input type="checkbox"/> cancer: _____ | <input type="radio"/> hives | <input type="radio"/> rashes |
| <input type="radio"/> change in body hair | <input type="radio"/> impotence | <input type="checkbox"/> rheumatic fever |
| <input type="radio"/> colic | <input type="radio"/> insomnia | <input type="radio"/> sore throat |
| <input type="radio"/> colitis / Crohn's Disease | <input type="radio"/> interstitial cystitis | <input type="radio"/> spots in vision |
| <input type="radio"/> cough | <input type="radio"/> itching | <input type="checkbox"/> stroke |
| <input type="radio"/> cystitis | <input type="radio"/> irritability | <input type="checkbox"/> seizures |
| <input type="radio"/> depression | <input type="checkbox"/> irritable bowel | <input type="checkbox"/> stomach / intestinal ulcers |
| <input type="checkbox"/> diabetes | <input type="radio"/> joint problems | <input type="radio"/> stuffiness |
| <input type="radio"/> distension | <input type="radio"/> kidney infections | <input type="radio"/> swelling |
| <input type="checkbox"/> drug problems | <input type="checkbox"/> kidney disease | <input type="radio"/> tearing eyes |
| <input type="radio"/> dry mouth | <input type="radio"/> lethargy | <input type="radio"/> thrush |
| <input type="checkbox"/> eating disorder | <input type="radio"/> loss of appetite | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> emotional challenges | <input type="radio"/> loss of interest in sex | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> extreme stress | <input type="checkbox"/> lupus | <input type="radio"/> vaginal burning or itching |
| <input type="radio"/> endometriosis | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> venereal disease |
| <input type="radio"/> extreme mood swings | <input type="radio"/> menstrual cramping | <input type="radio"/> white patches |
| <input type="radio"/> fatigue | <input type="checkbox"/> mental illness | <input type="checkbox"/> other: _____ |
| <input type="radio"/> fluid in ears | <input type="checkbox"/> migraine headaches | <input type="checkbox"/> other: _____ |
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I understand that the Nutritional Consultant I am here to see is not a medical doctor and I am not here for purposes of diagnosis or medical treatment. I understand that the purpose of my visit here is to gain a better understanding of my health, have more self-awareness of dietary patterns, and to learn some information about general nutrition so that I can make my own decisions about my health and steps I can take to increase overall wellness. I understand that any discussion of nutrition and dietary habits, nutritional supplements, vitamins, minerals, food grade herbs or self-care recommendations only pertains to the whole body concept of nutrition and wellness, and does not relate in the context of any specific ailment or condition. The appointments do not involve diagnosing, prognostication, treating or prescribing of medicines for the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a medical license is required.

Signature: _____ Date: _____