Nutrition & Health Assessment

Name: _____ Date: _____
Address: _____ City: _____
State: _____Zip: _____ Phone: _____ Email: _____
Reason for Consultation: _____
Date of Birth: ___/___/____ Age: ___M/F: ___ Marital Status: ___ Children: ____ Height: ____
When was your last physical exam? _____
Referred By: _____

Client Signature: _____Date: _____
Print Client Name: _____

Concerns
What health and/or nutrition concerns would you like to focus on during your visit?
1.
2.
3.

Brief Medical History: Please indicate (X) whether you have had any of the following conditions:

(X)	Illness	When	Comments
	High Blood Pressure		
	Heart Disease		
	Heart Attack		
	Diabetes		
	High Cholesterol		
	Irregular Heart Beat		
	Chest Pain		
	Dizziness		
	Heart Murmur		
	Shortness of Breath		
	Respiratory Disease		
	Epilepsy		
	GI Disorder		
	Orthopedic Condition		
	Osteoporosis		
	Hernia		
	Arthritis		
	Thyroid Disease		
	Stroke		
	Hypoglycemia		
	Anemia		
	Cancer		
	Blood Disorder		
	Lactose Intolerant		
	Old Injuries		
	Surgery		

Please indicate all medications you are currently taking:

Medication Name	Date Started	Dosage	How often	Consistently
1.			Times/Day	
2.			Times/Day	
3.			Times/Day	
4.			Times/Day	
5.			Times/Day	
6.			Times/Day	
7.			Times/Day	
8.			Times/Day	

Are you allergic to any medications? Yes No

If yes, please list: _____

Please list all **vitamins, minerals**, and other **nutrition supplements** that you are taking.

Vitamin/Mineral/ Herbal Supplement	Date Started	Dosage	Form of Vitamin/Mineral	How often
1.				Time/Day
2.				Time/Day
3.				Time/Day
4.				Time/Day
5.				Time/Day
6.				Time/Day
7.				Time/Day
8.				Time/Day

Brief <u>Family</u> Medical History: Do any of your blood relatives (brother, sister, parents, grandparents, aunts, uncles, etc.) have or had:

(X)	Illness	Family Member
	Allergies	
	Stomach ulcer	
	High Cholesterol	
	Digestive Disease	
	Multiple Sclerosis	
	Environmental Sensitivities	
	Alzheimer's/Dementia	
	Asthma	
	Anemia	
	Depression	
	Anorexia	
	Eating Disorder	
	Diabetes	
	Liver Disease	
	Stroke	
	Cancer	
	Obesity	
	Autoimmune disorder	
	Autism	
	Thyroid Disease	

Physical Activity

What are your hobbies and leisure activities:

_____

Do you exercise regularly □ Yes □ No

If so, how many times per week?

□ 1x
□ 2x
□ 3x
□ 4x

When you exercise how long is each session?

□ < 15 minutes
□ 15-30 minutes
□ 30-60 minutes
□ > 60 minutes

What Type of exercise do you perform? _____

How long have you been working out? _____

How long does it take you to recover after working out? _____

How active are you at your job or school?

□ Sedentary: *Sitting*
□ Light: *Standing*
□ Moderate: *Walking*
□ Active: *Manual Labor*

Social History:

What is your highest level of schooling? _____

What is your current occupation? _____

How long have you been there? _____

How much time have you lost from work or school in the past year?

□ 0-2 days □ 3-7 days □ 7-14 days □ >14 days

How would you rank the stress related to your job? (1= no stress 10=high stress)

1 2 3 4 5 6 7 8 9 10

What is your marital status?

□ Single □ Married □ Divorced □ Widow(er)

Do you have any children? □ Yes □ No If yes, how many? _____

Do you have any animals? □ Yes □ No If yes, how many? _____

If yes, where do they live? □ Indoors □ Outdoors □ Both Indoors and Outdoors

Have you ever used alcohol? □ Yes □ No

If yes, how many drinks per week? □ 1-3 □ 3-5 □ 5-7 □ 7-9 □ 9-11 □ >11

Have you ever had a problem with alcohol? □ Yes □ No

If yes please indicate from time period (month/year) From_____ to _____.

Have you ever used drugs? □ Yes □ No

Have you ever used tobacco? □ Yes □ No

If yes, number of years as a nicotine user: _____ Amount per day _____ Year quit____

If yes, type of nicotine have you used? □ cigarettes □ chewing tobacco
□ Cigar □ Pipe □ Patch/Gum

Are you exposed to second hand smoke? □ Yes □ No

Description of Daily Schedule- List Times Only

Morning	Afternoon	Evening
Wake-up: Workouts: Breakfast: Snacks:	 Workouts: Lunch: Snacks:	Workouts: Dinner: Snacks: Bedtime:
Notes:	Notes:	Notes:

Current Diet:

Food Diary: Please record what you eat and drink during one typical day (24 hour period).
Please be sure to include all beverages, cream and sweetener added to beverages, and condiments added to foods.

Time woke up:		Bedtime:	
Time	Food / Beverage Items	Amount (e.g. cups, oz., tsp)	Location (Home/Away)
5:00am	Egg Whites	½ cup	Home

Do you drink caffeinated beverages? □ Yes □ No If yes, how many cups per day?
Do you use any natural or artificial sweeteners? □ Yes □ No If yes, which ones?
What is your favorite meal?
Check all of the factors that apply to your eating habits and current lifestyle:
□ Love to Eat □ Love to Cook □ Emotional eater □ Late night eater
□ Struggle with eating issues □ Family members have different tastes □ Dislike Cooking
□ Erratic eating patterns □ Eat too much □ Rely on convenience foods □ Eat fast food regularly □ Make poor snack choices □ Don't meal prep □ Confused about food/nutrition □ Time constraints □ Travel Frequently □ Eat only because I have to □ Negative relationship with food □ Don't know how to cook

Food Frequency Questionnaire – How often do you eat the following?						
Food	**Never or <4x/year**	**Rarely or <4x/month**	**Once/wk**	**2x/wk**	**3x/wk**	**Daily**
Cheese	☐	☐	☐	☐	☐	☐
Yogurt, Kefir	☐	☐	☐	☐	☐	☐
Cow's Milk	☐	☐	☐	☐	☐	☐
Milk Substitute (soy, coconut, almond, rice, or hemp seed milk)	☐	☐	☐	☐	☐	☐
Red Meat	☐	☐	☐	☐	☐	☐
Pork (pork loin, pork roast, pork chops, barbecue)	☐	☐	☐	☐	☐	☐
Processed Meat (sausage, bacon, lunch meat)	☐	☐	☐	☐	☐	☐
Chicken	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐
Cold Water Fish (*wild Alaskan salmon, herring, sardines, anchovies, mackerel, halibut, cod)*	☐	☐	☐	☐	☐	☐
Other fish or shellfish- Indicate type:	☐	☐	☐	☐	☐	☐
Beans, Legumes (black beans, kidney beans, white beans, lentils)	☐	☐	☐	☐	☐	☐
Whole Soy Foods (edamame, soy nuts)	☐	☐	☐	☐	☐	☐
Tofu, Tempeh	☐	☐	☐	☐	☐	☐
Soy "meat alternative" (ex. Tofurkey, soy)	☐	☐	☐	☐	☐	☐
Berries	☐	☐	☐	☐	☐	☐
Other Fruits- Indicate type:	☐	☐	☐	☐	☐	☐
Cruciferous Vegetables (cabbage, broccoli, Brussels sprouts)	☐	☐	☐	☐	☐	☐
Green Leafy Vegetables (e.g. spinach, kale)	☐	☐	☐	☐	☐	☐
Yellow Fruits and Vegetables (e.g. yellow peppers, corn)	☐	☐	☐	☐	☐	☐
Other Green Fruits and Vegetables (e.g. peas, broccoli, avocado, cucumbers)	☐	☐	☐	☐	☐	☐
Blue/Purple Fruits and Vegetables (e.g. blueberries, prunes, beets, purple cabbage)	☐	☐	☐	☐	☐	☐
Red Fruits and Vegetables (e.g. cherries, apples, tomatoes, kidney beans)	☐	☐	☐	☐	☐	☐
Orange Fruits and Vegetables (e.g. orange, cantaloupe, carrots, sweet potato)	☐	☐	☐	☐	☐	☐
White/Tan Fruits and Vegetables (e.g. onions, garlic, ginger, nuts)	☐	☐	☐	☐	☐	☐
Turmeric, Cumin, Ginger, Rosemary, Oregano, Parsley	☐	☐	☐	☐	☐	☐

Food	**Never or <4x/year**	**Rarely or <4x/month**	**Once/wk**	**2x/wk**	**3x/wk**	**Daily**
Nuts, Nut Butters- Indicate type:	☐	☐	☐	☐	☐	☐
Avocado, Extra Virgin Olive Oil, Canola Oil	☐	☐	☐	☐	☐	☐
Vegetable oil (corn, sunflower, safflower, etc. – NOT olive oil)	☐	☐	☐	☐	☐	☐
White Rice	☐	☐	☐	☐	☐	☐
White Pasta	☐	☐	☐	☐	☐	☐
White Bread	☐	☐	☐	☐	☐	☐
Bagels	☐	☐	☐	☐	☐	☐
English Muffins	☐	☐	☐	☐	☐	☐
Pancakes or Waffles	☐	☐	☐	☐	☐	☐
Buttermilk Biscuits	☐	☐	☐	☐	☐	☐
Chips	☐	☐	☐	☐	☐	☐
Pretzels	☐	☐	☐	☐	☐	☐
Popcorn	☐	☐	☐	☐	☐	☐
Other Snack Food (crackers, Goldfish)	☐	☐	☐	☐	☐	☐
100% Whole Wheat, Rye, Barley (whole wheat bread and pasta)	☐	☐	☐	☐	☐	☐
Other Whole Grains (millet, quinoa, amaranth, flax, oats, brown rice)	☐	☐	☐	☐	☐	☐
Ice Cream	☐	☐	☐	☐	☐	☐
Pastries, cookies, cakes	☐	☐	☐	☐	☐	☐
Juice- Indicate type:	☐	☐	☐	☐	☐	☐
Soda	☐	☐	☐	☐	☐	☐
Red Wine	☐	☐	☐	☐	☐	☐
Tea (white, green, black)	☐	☐	☐	☐	☐	☐

Are you on a special diet? ☐ Yes ☐ No

☐ Ovo-lacto ☐ Vegetarian ☐ Other
☐ Dietary restricted ☐ Vegan ☐ Diabetic
☐ Blood type diet

Do you feel significantly **worse** when you eat a lot of:

☐ High Fat Foods ☐ Refined Sugar (junk food) ☐ High Protein Foods
☐ Fried Foods ☐ High Carbohydrate Foods ☐ 1 or 2 Alcoholic drinks
☐ Other: _____

Do you feel significantly **better** when you eat a lot of:

☐ High Fat Foods ☐ Refined Sugar (junk food) ☐ High Protein Foods
☐ Fried Foods ☐ High Carbohydrate Foods ☐ 1 or 2 Alcoholic drinks
☐ Other: _____

Ed TenEyck MSACN

Toxin Exposure:

Do you have any mercury amalgam fillings? □ Yes □ No
Do you have any artificial joints or implants? □ Yes □ No
Do you feel worse at certain times of the year? □ Yes □ No
If yes, when? □ Spring □ Summer □ Fall □ Winter
Have you ever been exposed to toxic metals in your job or at home? □ Yes □ No
If yes, which ones? □ Lead □ Cadmium □ Arsenic □ Mercury □ Aluminum
Are you exposed to any of the following?
□ Paint fumes □ Perfumes □ Nail Polish □ Auto Exhaust
□ Chemicals □ Hair Dyes □ Dry-Cleaned Clothes

For Women only

Have you ever been pregnant? □ Yes □ No
Number of miscarriages ____ Number of abortions ____ Number of preemies ___
Number of term births ____ Birth weight of largest baby _____ Smallest baby _____
Did you develop toxemia (high blood pressure)? □ Yes □ No
Have you had other problems with pregnancy? □ Yes □ No
If so, please explain: _____
Have you ever used birth control pills? □ Yes □ No If so, when? _____
Did taking the pill agree with you? □ Yes □ No □ N/A
Do you currently use contraception? □ Yes □ No
If so, what type? _____
Are you in menopause? □ Yes □ No If so, age at last period? _____
Do you take: □ Estrogen □ Ogen □ Estrace □ Premarin
□ Progesterone □ Provera □ Other: _____
How long have you been on Hormone replacement therapy? _____

Symptom Survey

Completing this form is particularly helpful if you have experienced persistent and bothersome symptoms from more than one category below. Score every symptom based on your experience over the last 30 days. Start with the first symptom and ask yourself, "Lately, have I experienced this symptom?" If you answer no or almost not at all, then write a "0" in the corresponding field. If the answer is yes, then ask yourself if you experience the symptom occasionally (less than 2 times in a week) or frequently (2 or more times in a week). After you have decided on the frequency, then ask yourself if the symptom is "Severe" or "Not Severe". Using the SCALE OF SYMPTOM POINTS listed below, write the appropriate score in the corresponding field for EVERY symptom listed. Total the points for each category, and add all category totals to come up with the Grand Total.

SCALE OF SYMPTOM POINTS:	Grand Total:
0 = Do Not Suffer from this Ever or Almost Ever 1 = Suffer OCCASSIONALLY (less than 2 times per week), is not severe 2 = Suffer FREQUENTLY (2 or more times per week), is not severe 3 = Suffer OCCASSIONALLY and is severe 4 = Suffer FREQUENTLY and is severe	

General	Points	Emotional	Points	Head/Ears	Points
Fatigue		Depression		Headache	
Hyperactive		Anxiety		Earache	
Restless		Mood Swings		Ear Infection	
Sleepiness during the day		Irritability		Ringing in the ear	
Insomnia at Night		Forgetfulness		Itchy Ears	
Malaise		Lack of concentration			
Total		Total		Total	
Skin	**Points**	**Nasal/Sinus**	**Points**	**Mouth Throat**	**Points**
Blemishes, acnes		Post Nasal Drip		Sore Throat	
Rashes, Hives		Sinus Pain		Swollen Throat	
Eczema		Runny Nose		Swelling of the lips/tongue	
Rosy cheeks		Stuffy nose		Gagging/ throat clearing	
		Sneezing		Lesions (canker sores)	
Total		Total		Total	
Lungs	**Points**	**Eyes**	**Points**	**Genitourinary**	**Points**
Wheezing (asthma)		Red or swollen eyes		Increased urinary frequency	
Chest Congestion		Watery eyes		Painful urination	
Non-productive coughing		Itchy eyes			
Productive coughing		Dark Circles/ bags			
Total		Total		Total	
Musculoskeletal	**Points**	**Cardiovascular**	**Points**	**Digestive**	**Points**
Joint pains/ aches		Irregular Heart Beat		Heartburn/ Reflux	
Stiff joints		High Blood Pressure		Stomach pains/ cramps	
Muscle aches				Intestinal pains/ cramps	
Stiff Muscles				Constipation	
				Diarrhea	
				Bloating sensation	
				Gas	
				Nausea, Vomiting	
Total		Total		Total	
Eating	**Points**	**Hair**	**Points**	**Lymph**	**Points**
Binge Eating		Loss of chest and armpit hair		Enlarged/ Neck	
Bulimia		Loss of eyebrow hair		Tender/ Neck	
Can’t gain weight		Loss of lower leg hair		Other enlarged/ tender lymph nodes	
Can’t lose weight					
Carbohydrate Craving					
Carbohydrate intolerance					
Total		Total		Total	