Nutrition Speak

Client Health Information

Please take time to complete these pages carefully and thoroughly.
The information will help me make a meaningful assessment of your health and individual needs.
All your information is kept confidential.

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email _____

(Please circle best phone to reach you or leave a message.)

Occupation/Type of Work or When Retired _____

Emergency Contact _____ Relationship _____ Phone _____

Who referred you or how did you hear about my practice? _____

_____

Age _____ Birthdate _____ Recent Blood Pressure _____

Current Height _____ Height at age 30 _____ Recent Cholesterol _____

Current Weight _____ Comfortable Weight _____ Recent Blood Sugar _____

Your Blood Type _____

Nutrition Speak

Your Healthcare Practitioners

Please list your most important practitioners, including medical and naturopathic physicians, chiropractors, massage therapists, acupuncturists or any other specialists.
If you don't have a phone number, please leave the line blank.

1) Primary Care Practitioner's Name _____

Title/Type of Practice _____

Phone _____ City _____

Office Use: _____

_____

2) Practitioner's Name _____

Title/Type of Practice _____

Phone _____ City _____

Office Use: _____

_____

3) Practitioner's Name _____

Title/Type of Practice _____

Phone _____ City _____

Office Use: _____

_____

4) Practitioner's Name _____

Title/Type of Practice _____

Phone _____ City _____

Office Use: _____

_____

Nutrition Speak

Health Information

1) Please describe your major health concerns.

2) What specific health issues do you want to address with me?

3) Surgeries and Major Illnesses Please note your age at the time.

4) Significant Past Traumas and Current Stressors (Physical and Emotional) Please note your age at the time.

5) Allergies and Sensitivities Include chemical, environmental, airborne, foods, medications and supplements.

6) Exercise Routines or Regular Physical Activities

Nutrition Speak

Symptom Checklist

Please CHECK all symptoms you've had ANY TIME IN THE LAST YEAR.
Please CIRCLE all symptoms you've EVER HAD and WANT TO DISCUSS.

GENERAL
_____ Fatigue
_____ Food allergies/intolerances
_____ Low Blood pressure
_____ Poor sleep
_____ Reduced appetite
_____ Significant thirst
_____ Sudden energy drops
_____ Too hot or cold
_____ Weight gain or loss >10 lbs.

GASTROINTESTINAL
_____ Abdominal bloating
_____ Abdominal pain/cramps
_____ Acid reflux/GERD
_____ Always hungry
_____ Bad breath
_____ Belching
_____ Celiac disease
_____ Changes in appetite
_____ Constipation/hard stools
_____ Cravings
_____ Crohn's disease
_____ Diarrhea
_____ Diverticulosis/ Diverticulitis
_____ Excessive Gas
_____ Frequent laxative use
_____ Gallbladder trouble
_____ Hemorrhoids
_____ Hiatal hernia
_____ IBS (Irritable Bowel Syndrome)
_____ Indigestion
_____ Infrequent stools (< 1x/day)
_____ Loose stools (> 2x/day)
_____ Nausea, even mild
_____ Ulcer

CARDIOVASCULAR
_____ Heart disease
_____ High blood pressure
_____ High cholesterol
_____ Shortness of breath
_____ Varicose/spider veins

MUSCULOSKELETAL
_____ Arthritis/joint pain
_____ Leg cramps/aching/restless
_____ Muscle pain
_____ Muscle weakness
_____ Neck or back pain/stiffness
_____ Swollen feet/ankles

MENTAL AND EMOTIONAL HEALTH
_____ ADD/ADHD
_____ Alcoholism/drug addiction
_____ Anxiety/worry a lot
_____ Depression
_____ Difficulty relaxing
_____ Easily susceptible to stress
_____ Irritability/easy temper
_____ Panic attacks
_____ PTSD

RESPIRATORY
_____ Asthma
_____ Bronchitis
_____ Chronic cough
_____ Pneumonia
_____ Respiratory allergies
_____ Tight sensation in chest

Nutrition Speak

GENITO-URINARY

_____ Burning urination
_____ Frequent urination
_____ Genital herpes
_____ Incontinence (unable to hold urine)
_____ Kidney stones
_____ Night urination – times: _____
_____ Painful urination
_____ PSA elevated/prostatitis
_____ Urgent urination
_____ Urinary tract infection
_____ Urine brown, black or cloudy
_____ Weak urination /scanty flow

GYNECOLOGICAL/REPRODUCTIVE

_____ Endometriosis
_____ Heavy bleeding
_____ Hot flashes
_____ Ovarian Cysts
_____ Pain or bleeding with intercourse
_____ Painful menstruation/cramps
_____ PCOD (Polycystic Ovarian Disease)
_____ PMS (Pre-Menstrual Syndrome)
_____ Uterine fibroids

Date of last menses: _____
Number of children: _____

SKIN, HAIR AND NAILS

_____ Acne
_____ Bleed/bruise easily
_____ Difficulty healing cuts
_____ Eczema/psoriasis
_____ Face flushing/rosacea
_____ Fungal infection under nails
_____ Hives/allergic dermatitis
_____ Increased daily hair loss
_____ Itching or burning skin
_____ Moles
_____ Rashes
_____ Weak or ridged nails
_____ White spots on nails

HEAD, EARS, NOSE AND THROAT

_____ Airborne or contact allergies
_____ Canker sores
_____ Chronic sinusitis
_____ Cold sores
_____ Dental/gum problems
_____ Difficulty swallowing
_____ Difficulty swallowing pills
_____ Ear infection
_____ Earache
_____ Frequent colds
_____ Headaches
_____ Hoarseness
_____ Migraines
_____ Sinus problems
_____ Sore throat, even mild/occasional

OTHER

_____ Adrenal fatigue
_____ Anemia
_____ Cancer – type: _____
_____ Diabetes: Type I or Type II (circle)
_____ Fibromyalgia
_____ Hepatitis – type: _____
_____ Hypoglycemia
_____ Insulin Resistance
_____ Lyme disease
_____ Smoking/nicotine dependence
_____ Thyroid imbalance