



CLIENT INTAKE FORM

Date:

Legal Name:

How do you like to be addressed?

Date of Birth:

Home Address:

Home/Cell Phone:

Work Phone:

Email Address:

Referred by:

Please indicate the doctors or practitioners that have been involved in your care in the last three years.

- | | |
|---|--|
| <input type="checkbox"/> Primary Care Physician | <input type="checkbox"/> Urologist/Nephrologist |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Herbalist |
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Gastroenterologist | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Surgeon | <input type="checkbox"/> Hematologist/Oncologist |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Endocrinologist |
| <input type="checkbox"/> Gynecologist | <input type="checkbox"/> Naturopathic Physician |
| | <input type="checkbox"/> Other |

What is your gender?

- | | |
|---|---|
| <input type="checkbox"/> Female | <input type="checkbox"/> Male |
| <input type="checkbox"/> Transgender: FTM | <input type="checkbox"/> Transgender: MTF |
| <input type="checkbox"/> Other: _____ | |

What is your ethnicity?

- | | |
|---|---|
| <input type="checkbox"/> Hispanic or Latino/a Mexican | <input type="checkbox"/> Latin America Non-Hispanic or Latino/a |
|---|---|

What is your race?

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African | <input type="checkbox"/> Other |

CONCERNS

What do you hope to achieve in your visit with me? (List all concerns you would like to address)

When was the last time you felt well?

If known, what trigger changed your health?

How many days of work or school have you missed in the past 12 months due to your health?

- | | |
|-------------------------------|------------------------------|
| <input type="checkbox"/> <5 | <input type="checkbox"/> <15 |
| <input type="checkbox"/> > 15 | |

Readiness Assessment

- 5= Very ready, I can do this!
- 4= Ready, but I have some concerns about implementing it
- 3= Somewhat ready
- 2= I don't think I want to do this now but maybe in the future
- 1= Not ready

- | | |
|---|--|
| <input type="checkbox"/> Significantly change my diet | <input type="checkbox"/> Record my daily food intake |
| <input type="checkbox"/> Participate in regular physical activity | <input type="checkbox"/> Participate in forms of stress management |
| <input type="checkbox"/> Improve my sleep | <input type="checkbox"/> Take supplements daily |

How motivated are you to resolve your health concerns?

- Extremely motivated doing whatever it takes!
- Very motivated but I might have some barriers.
- Somewhat motivated but this is my starting point.

What barriers might interfere with your reaching your health goals or implementing a nutrition protocol?

- Finances
- Significant other/family/friends
- Time/ Time Management
- Travel Schedule
- Social Environment
- Cooking Skills
- Other _____

FAMILY HISTORY

Have any blood relatives ever had any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness or suicide |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Genetic Disorder |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Infertility |

Indicate who below (grandmother, father, sister, etc.)

Grandparents:

Ages:

Living or Deceased:

Parents:

Ages:

Living or Deceased:

Siblings:

Ages:

Living or Deceased:

PERSONAL MEDICAL HISTORY

Who is your Primary Care Physician? Please include address, phone number, and fax number.

Birth History

Did your mother have any pregnancy or delivery complications with you?

Were you born Term Premature

Were you Breastfed Bottle Fed

Did you eat a lot of sugar as a child? Yes No

Medical Diagnosis

Indicate any medical diagnosis, past or current

GASTROINTESTINAL

- | | |
|--|---|
| <input type="checkbox"/> Irritable bowel disease | <input type="checkbox"/> Inflammatory bowel disease (Crohn's or Ulcerative colitis) |
| <input type="checkbox"/> Gastritis | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> GERD (reflux) | <input type="checkbox"/> Gallbladder removal |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other |

CARDIOVASCULAR

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hypotension |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Elevated cholesterol |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Other | |

METABOLIC/ENDOCRINE

- | | |
|---|--|
| <input type="checkbox"/> Type 1 Diabetes | <input type="checkbox"/> Type 2 Diabetes |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Metabolic Syndrome |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> PCOS | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Binge eating disorder | <input type="checkbox"/> Night eating syndrome |
| <input type="checkbox"/> Eating disorder (non-specific) | <input type="checkbox"/> Other _____ |

CANCER

- | | |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Lung | <input type="checkbox"/> Breast |
| <input type="checkbox"/> Colon | <input type="checkbox"/> Ovarian |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Other | |

GENITAL/URINARY

- Kidney Stones
- Interstitial Cystitis
- Yeast infection
- Other
- Gout
- Urinary Tract Infection
- Erectile dysfunction

MUSCULOSKELETAL

- Osteoarthritis
- Fibromyalgia
- Other
- Osteoporosis
- Chronic Pain

INFLAMMATION/AUTOIMMUNE

- Chronic fatigue syndrome
- Lupus/SLE
- Immune Deficiency disease
- Severe infectious disease
- Food Allergies
- Latex Allergy
- Other Autoimmune Disease
- Hashimoto's Thyroiditis
- Rheumatoid Arthritis
- Herpes-genital
- Poor Immune Function
- Environmental Allergies
- Multiple Chemical Sensitivities

RESPIRATORY

- Asthma
- Bronchitis
- Tuberculosis
- COPD
- Chronic Sinusitis
- Emphysema
- Sleep Apnea
- Other

SKIN

- Eczema
- Acne
- Other
- Psoriasis
- Hives

NEUROLOGICAL/MOOD

- Depression
- Bipolar Disorder
- Headaches
- ADD/ADHD
- Mild cognitive impairment
- Alzheimer's
- ALS
- Drug Abuse
- Anxiety
- Schizophrenia
- Migraines
- Autism
- Dementia
- Multiple Sclerosis
- Seizures
- Alcohol Abuse
- Other

List any other diagnosis or illnesses not listed above

List all hospitalizations, including reason and date occurred?

Please list any major accidents (motor vehicle, sports, etc.) with dates and site of injury

Date of last physical exam?

Date of last blood work?

Medical Imaging & Testing

X-ray: Provide date, area of body, and reason?

Ultrasound: Provide date, area of body, and reason?

MRI/CAT Scan: Provide date, area of body, and reason?

GI Series: Provide date, area of body, and reason? (colonoscopy, endoscopy)

Other tests: Provide date, area of body, and reason? (Cardiac Stress test, EKG, others)

Surgeries

Select box and provide the date of surgery

- Appendectomy_____
- Hysterectomy_____
- Gallbladder_____
- Hernia_____
- Tonsillectomy_____
- Dental_____
- Joint Replacement_____
- Heart_____
- Angioplasty/Stent_____
- Pacemaker_____
- Other_____
- None

Blood Type?

- A B AB O Rh+ Unknown

Provide any known genetic information (i.e. MTHFR, BRCA, etc.)

GI History

- Any foreign travel? Yes No
- Any wilderness camping? Yes No
- Did any of your GI symptoms worsen or seem unresolved after foreign travel or camping? Yes No
- Have you ever had severe? Gastroenteritis Diarrhea
- Do you feel like you digest food well? Yes No
- Do you bloat after meals? Yes No
- If yes, how soon following a meal? _____
- If yes, does a bowel movement or passing gas relieve it?
 Yes No
- If yes, where do you feel bloated? _____
 Upper abdominal Lower abdominal Both
- How many bowel movements do you have per day?
 1 2 3 Every other day Other

General form?

- Well Mushy Soft Watery
- Pellets Other _____
- General Color _____

Do your stools:

- Float Sink Both

Have you had exposure to or history of?

- Parasites
- C-Diff
- Candida
- Other bacteria/virus

Weight History

- Height _____ Current Weight _____
- Usual weight range +/- 5 lbs. _____
- Desired weight range +/- 5 lbs. _____
- Highest adult weight _____ Lowest Adult Weight _____
- Have you recently had undesired or unexplained weight loss?
 Yes No
- Have you ever had your resting metabolic rate checked?
 Yes No
- How often do you weight yourself?
 Daily Weekly Monthly Never/Rarely

Allergies

Please indicate any allergies. (Do not include intolerances)

- No known or suspected allergies
- Medication
- Foods
- Environmental

Please indicate allergy and describe reaction:

Medications & Supplements

List all known allergies to medications or supplements:

Current Medications (include prescribed and over the counter)

Medication	Dose	Frequency	Time of day taken	Start Date	Reason for Use	Prescribed by

Previous Medications (include prescribed and over the counter taken in the past 12 months)

Medication	Dose	Frequency	Date Stopped	Reason for Use	Prescribed by

Nutritional Supplements (vitamins, minerals, herbs, homeopathy)

Supplement: Include Brand	Dose	Frequency	Time of day taken	Start Date	Reason for Use	Prescribed by

Have your medications or supplements ever caused you any side effect or problems? Yes No

Have you had prolonged use of NSAIDs (Advil, Aleve, Motrin) or aspirin? Yes No

Have you had prolonged or regular use of Tylenol? Yes No

Have you had prolonged use or regular use of acid blocking drugs (Tagamet, Prilosec, Nexium, etc.)? Yes No

How many times per year do you take antibiotics? _____

Have you taken antibiotics long-term at any time in your life? Yes No

Were you given antibiotics often as a child? Yes No

Have you used steroids (prednisone, nasal allergy inhalers, etc.) in the past? Yes No

Have you taken oral contraceptives in the past? Yes No

SOCIAL HISTORY

What is your current job?

Do you enjoy your job? Yes No
How many hours do you work each week? _____

What are your hobbies?

Relationship

Relationship status?

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Married | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Domestic partner | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> In a relationship | <input type="checkbox"/> Other |

Are you satisfied with your significant relationships?

- Yes No

Do you live alone?

- Yes No

Do you have a support system?

- Strong Moderate Limited

LIFESTYLE HISTORY

Stress

Do you feel you have an excessive amount of stress in your life that is impacting your health or well-being?

- Yes No

Major stressors in the last year? Rate on a scale of 1-10 (10 being the most stressful)

- Money _____
- Job _____
- Marriage/relationship _____
- Social life _____
- Children _____
- Loss _____
- Health Concerns _____
- Other _____

Are you currently in therapy? Yes No

Do you practice any relaxation techniques? Yes No

If yes, check all that apply:

- Yoga
- Meditation
- Guided Imagery
- Breathing
- Tai Chi
- Prayer
- Other _____

Do you find your life?

- Satisfactory
- Unsatisfactory
- Boring
- Too demanding

Sleep

Time to bed _____ Time you wake _____

Do you sleep and wake at the same time on the weekend and weekdays? Yes No

Do you wake feeling refreshed?

- Always Usually Rarely Never
Are you a Morning Person Night Owl Neither

Do you have difficulty sleeping? Yes No

Any trouble falling asleep? Yes No

Any trouble staying asleep? Yes No

Do you snore? Yes No

Do you grind your teeth? Yes No

Do you have nightmares? Yes No

Do you sleepwalk? Yes No

Do you wake due to pain? Yes No

Do you dream? Yes No

How many times do you wake during the night?

- none once twice more

What is the reason for waking?

- bathroom use
- pain
- racing mind
- child/children
- pet
- significant other
- other _____

Do you need a sleep-aid?

- Yes, indicate what No

Energy

Please indicate your average level of energy throughout the day using the scale 1-10 (1 is the lowest and 10 is the highest)
Overall:

Upon waking:

Noon:

Mid Afternoon:

Early Evening (5-6pm):

Are you easily fatigued? Yes No

Do you nap during the day? Yes No

If yes, does it improve your energy? Yes No

If you could nap during the day, would you? Yes No

Alcohol, Tobacco, and Recreational Drug Use

Do you drink alcohol?

- Daily Weekly Monthly
 Less than monthly Special Occasions

What type of alcohol do you prefer?

- Liquor Wine Beer Other

How much do you drink per sitting? Indicate amount consumed per occasion.

Do you smoke or chew tobacco?

- Yes No In the past

If yes, how many cigarettes or packs per day?

If past, when did you quit smoking/chew, number of years smoking/chew, and packs per day?

Do you use recreational drugs?

- Yes No In the past

If yes, how often?

- Daily Weekly Monthly Other

If Yes or in the past, what kind?

- Cannabis Barbiturates/benzodiazepines
 Solvents Psychedelic mushrooms
 Heroin LSD
 Opium Peyote
 Ecstasy Amphetamines
 Cocaine Other

Have you ever been told you have an addiction or been treated for an addiction?

- Yes No

Does the use of alcohol or drugs impair your activities of daily living?

- Yes No

Physical Activity

Are you currently engaging in regular physical activity?

- Yes No

If yes, indicate details below.

If no, list any activities you enjoy doing or have enjoyed in the past

Aerobic/Cardio Type: _____

Times per week _____ Duration _____

Strength Training

Times per week _____ Duration _____

Stretching

Times per week _____ Duration _____

Formal Sports (basketball, tennis, etc.)

Times per week _____ Duration _____

Other Activity

Times per week _____ Duration _____

Do you continue to exercise when under stress or busy?

- Yes No

Do you usually sweat with exercise? Yes No

Do you feel unusually fatigued after exercise?

- Yes No

List any concerns that limit your ability for physical activity:

Environmental Exposures

Which of the following significantly affect you?

- Cigarette Smoke Perfumes/Colognes
 Exhaust Fumes Cleaning Products
 Other _____

Which of the following are you exposed through home, work or school?

- Electromagnetic radiation Mold
 Cleaning Products Pesticides
 Herbicides Fungicides
 Insecticides (exterminators) Heavy Metals
 Dry cleaning of clothes Organic Solvents
 Other _____

Do you have any pet or farm animals? Yes No

Nutrition

Have you ever had a nutrition consultation? Yes No

Have you made changes in your eating habits because of health concerns? Yes No

Do you currently follow a special diet or nutritional program?

- Yes No If yes, select all that apply
- Low Fat Low Carb/Keto/Atkins
 - Low Sodium High Protein/Paleo
 - Gluten Free Mediterranean
 - Dairy Free Vegetarian/Vegan
 - Calorie restricted Fasting
 - Other

Do you have any known food allergies, sensitivities or intolerances? Yes No

If yes, provide the food and the type of reaction you experience.

Do you frequently skip or miss meals? Yes No

Do you read food labels? Yes No

Do you grocery shop? Yes No

Do you cook? Yes No

How many meals do you eat out each week?

- 0-1 2-3 4-5 >5

If you could only eat a few foods per week, what would they be?

What are the 3 healthiest foods you eat each week on a regular basis?

What are the 3 unhealthiest foods you eat each week?

How many meals do you eat a day?

How many 8oz cups of water do you drink daily?

Do you drink energy drinks?

- Daily Weekly Monthly No

Please indicate what kind of energy drink and how much:

Do you drink soda, juice or sports drinks?

- Daily Weekly Monthly No

Please indicate what kind of soda, juice or sports and how much:

How many 8oz cups of coffee do you drink daily?

Do you use sweeteners?

- Sugar Stevia Sweet-n-Low
 Equal Splenda Honey
 Xylitol Maple Syrup Other

Do you eat meals (check all that apply)

- In front of TV In the car At your desk
 Alone With others Other _____

What is your general mood when eating?

- Rushed Distracted Mindful
 Other _____

Do you adversely react to: (check all that apply)

- MSG Aspartame (NutraSweet) Caffeine
 Bananas Garlic Onion Cheese
 Citrus Fruit Alcohol Chocolate
 Preservatives Sulfite containing foods (wine, dried fruit, salad bars) Other

Check all factors that apply to your current lifestyle and eating habits:

- | | |
|--|--|
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Erratic eating patterns |
| <input type="checkbox"/> Poor snack choices | <input type="checkbox"/> Poor food choices |
| <input type="checkbox"/> Late night eating | <input type="checkbox"/> Negative relationship with food |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Love to eat |
| <input type="checkbox"/> Eat in the middle of the night | <input type="checkbox"/> Eat more than 50% of meals away from home |
| <input type="checkbox"/> Travel Frequently | <input type="checkbox"/> Do not plans meals/menus |
| <input type="checkbox"/> Significant other/family have special dietary needs | <input type="checkbox"/> Reliance on convenience foods |
| <input type="checkbox"/> Dislike healthy food | <input type="checkbox"/> Eat because I have to |
| <input type="checkbox"/> Eat too little under stress | <input type="checkbox"/> Emotional eater |
| <input type="checkbox"/> Don't care to cook | <input type="checkbox"/> Eat too much under stress |
| <input type="checkbox"/> Sugar binges | <input type="checkbox"/> Confused about nutrition advice |
| <input type="checkbox"/> Like to graze | <input type="checkbox"/> Eat 1 meal per day |
| <input type="checkbox"/> Eat bulk of calories early in day | <input type="checkbox"/> Eat bulk of calories later in day |
| <input type="checkbox"/> Significant other/family don't eat like me | <input type="checkbox"/> Forget to eat |
| | <input type="checkbox"/> Think about food all the time |

The most important thing I should change about my diet to improve my health is:

REVIEW OF SYSTEMS

Do you have, or have you had within the past year, any of the following?

General

- cold hands or feet
- cold intolerance
- heat intolerance
- chills
- fatigue
- night sweats

Eyes

- dryness
- watery eyes
- itching and redness of eyes
- eye strain
- cataracts
- stys
- dark circles around eyes
- discharge of the eye
- glaucoma
- contacts/glasses
- problems with vision

Date of last eye exam:

Ears/Nose/Throat

- ringing
- decrease in hearing
- ear discharge
- ear pain
- vertigo
- nose bleeds
- loss of smell
- postnasal discharge
- nasal congestion
- nasal discharge
- sinus pain
- sore throat
- hoarseness
- snoring
- mouth sores
- difficulty with swallowing
- bad odor in nose
- sinus infections

Cardiovascular

- murmurs
- palpitations
- irregular heartbeat
- swollen hands/feet
- blue hands/feet
- chest pain
- varicose veins

Respiratory

- cough-dry
- hay fever
- wheezing
- winter congestion
- cough-productive
- shortness of breath
- pain with breathing

Gastrointestinal

- bad breath
- indigestion
- diarrhea
- constipation
- lower abdominal pain
- burping
- canker sores
- cracking at corner of lips
- cramps
- cold sores
- upper abdominal pain
- heartburn
- ulcers
- hemorrhoids
- sense of fullness during and after meals
- mucus in stool
- heartburn
- gas/flatulence
- bleeding gums
- nausea
- vomiting
- bloating of whole abdomen
- bloating of lower abdomen
- bloating of upper abdomen
- dentures with poor chewing
- fatty meals bothering
- difficulty swallowing
- rectal bleeding
- rectal itching
- dry mouth
- food repeats/reflux
- sore tongue
- periodontal disease
- strong stool odor
- undigested food in stool

Urinary Tract

- incontinence
- kidney stones
- blood in urine
- urgency
- bed wetting
- frequent urination
- frequent infections
- pain with urination
- waking to urinate
- dark urine

Musculoskeletal

- muscle weakness
- muscle aches/pain
- joint injury
- TMJ
- muscle cramps/spasms
- joint stiffness
- joint pain
- joint deformity

Skin/Integumentary

- pale skin
- oily skin
- changes in mole size/color
- dry skin
- acne
- rash
- hives
- dry scalp
- athlete's foot
- easy bruising
- red face
- dry patches
- itchy skin
- sensitive to bites
- skin darkening
- strong body odor
- lack of sweating
- hair loss (head, arms, eyebrows, legs, chest)
- bumps on back of arms

Neurological

- paralysis
- sciatica
- seizures
- weakness
- headaches
- migraines
- sensitive to loud noise
- difficulty with balance
- difficulty with judgement
- numbness/tingling
- tremors
- head injury
- fainting/blackouts
- dizziness
- light-headedness
- difficulty with concentration
- difficulty with thinking
- difficulty with speech
- difficulty with memory

Mood/Emotional

- anxiety
- panic attack
- irritability
- depression
- suicidal thoughts
- anger

Endocrine

- hot intolerance
- cold intolerance
- Mood swings
- Snacking often
- Irritability
- increased urination
- increased thirst
- Hormone therapy
- Needing to eat regularly
- Change in glove/shoe size

Hematologic/Lymphatic

- anemia
- easy bruising/bleeding
- hemorrhoids
- swollen lymph nodes
- circulation issues
- fragile/sensitive skin
- Hx of blood clots
- Deep bone pain
- Reaction to insect bites
- Brittle nails

Allergic/Immunologic

- Seasonal allergies
- sensitivity to chemicals
- watery or itchy eyes
- congestion
- hx of organ transplant or donation
- Sick often
- rash
- hives
- environmental chemical exposure
- family hx of wheat allergy or celiac disease

Nails

- bitten
- curve up
- fungus
- ridges
- soft
- white spots/lines
- brittle
- frayed
- pitting
- ragged cuticles
- thickening
- spooning

Eating

- binge eating
- can't lose weight
- appetite: increase
- appetite: decreased
- craving for salt
- craving for chocolate
- craving or bread/pasta
- intolerance to lactose
- intolerance to gluten
- intolerance to fatty foods
- can't gain weight
- can't maintain healthy weight
- frequent dieting
- desire to snack often
- craving for sweets/sugar
- craving for caffeine
- carbohydrate intolerance
- lack/decreased taste
- need to eat every few hours
- intolerance to wheat
- intolerance to corn
- intolerance to eggs
- intolerance to yeast
- increased thirst
- decreased thirst
- Other _____

Dental

- tooth pain
- chewing difficulties
- floss daily
- bleeding gums
- trouble swallowing
- mercury fillings
- root canals

FEMALE SECTION

(Only females complete this section)

Menstrual Cycle

Age of first menses?

First day of last menses?

Length of menses?

Characters of menses such as color and clots?

Number of pads/tampons used on your heaviest day?

Number of pads/tampons used on your lightest day?

Do you have clots with the menstrual cycle?

- Yes No

Do you have pain during the menstrual cycle?

- Yes No

Have you ever skipped a period?

- Yes No

If yes, how long _____

Type of contraception used currently or in the past:

Do you experience any of the following premenstrual/menstrual symptoms?

- | | |
|---|--|
| <input type="checkbox"/> irritability | <input type="checkbox"/> breast tenderness |
| <input type="checkbox"/> headache | <input type="checkbox"/> cramps |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> depression |
| <input type="checkbox"/> bowel changes | <input type="checkbox"/> changes in libido |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> bloating |
| <input type="checkbox"/> chocolate cravings | <input type="checkbox"/> aggressiveness |
| <input type="checkbox"/> increased sleep | <input type="checkbox"/> carbohydrate cravings |
| <input type="checkbox"/> decreased sleep | |

Have you been diagnosed with any of the following?

- | | |
|--|--|
| <input type="checkbox"/> PCOS | <input type="checkbox"/> uterine fibroids |
| <input type="checkbox"/> infertility | <input type="checkbox"/> endometriosis |
| <input type="checkbox"/> fibrocystic breasts | <input type="checkbox"/> pelvic inflammatory disease |
| <input type="checkbox"/> PMDD | |

Menopause

Surgically induced menopause:

- Total hysterectomy Partial hysterectomy

Age at menopause:

Age your mother entered menopause:

During peri or post menopause, did you experience or are you currently experiencing:

- | | |
|---|--|
| <input type="checkbox"/> hot flashes | <input type="checkbox"/> mood changes |
| <input type="checkbox"/> night sweats | <input type="checkbox"/> incontinence |
| <input type="checkbox"/> vaginal dryness | <input type="checkbox"/> joint pain |
| <input type="checkbox"/> decreased libido | <input type="checkbox"/> changes in sleep |
| <input type="checkbox"/> palpitations | <input type="checkbox"/> brain fog or decreased memory |
| <input type="checkbox"/> headaches | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> weight gain | |

Date of last DEXA scan (bone scan):

Indicate if you never had one.

Breast Health

Do you have a history of breast cancer?

- Yes No

Do you have a family history of breast cancer?

- Yes No

Do you have any of the following?

- breast pain
 breast discharge
 breast masses

Date of last mammogram and results:

Gynecology and PAP History

Date of last PAP smear and results:

Have you ever had an irregular PAP smear?

- No Yes, list date and treatment received:
-

Check all the pelvic symptoms you currently experience:

- | | |
|--|---|
| <input type="checkbox"/> vaginal itching | <input type="checkbox"/> abnormal discharge |
| <input type="checkbox"/> vaginal odor | <input type="checkbox"/> rashes or skin changes |
| <input type="checkbox"/> pelvic pain | <input type="checkbox"/> pain with intercourse |
| <input type="checkbox"/> low libido | <input type="checkbox"/> bleeding after intercourse |

Pregnancy History

Number of pregnancies:

Number of miscarriages:

Number of abortions:

Any complications with pregnancy? Yes No

Any difficulty with conceiving? Yes No

Post-Partum depression? Yes No

Number of vaginal births:

Number of C-Sections:

MALE SECTION

(Only males complete this section)

Prostate, urinary, or pelvic symptoms?

- | | |
|--|--|
| <input type="checkbox"/> testicular pain | <input type="checkbox"/> incomplete urination |
| <input type="checkbox"/> testicular swelling | <input type="checkbox"/> hernia |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> penial discharge |
| <input type="checkbox"/> nocturia | <input type="checkbox"/> dribbling of urine |
| | <input type="checkbox"/> difficulty initiating urination |
| <input type="checkbox"/> prostatitis | <input type="checkbox"/> BPH |
| <input type="checkbox"/> prostate cancer | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> rash/blisters/skin changes on penis | <input type="checkbox"/> Difficulty in achieving an erection |
| <input type="checkbox"/> fertility challenges | <input type="checkbox"/> Difficulty maintaining an erection |

Date of your last PSA?

Date of your last prostate exam (digital rectal exam)?

Additional Information

Is there anything else you would like your nutritionist to know about you?
