WELLNESSTHROUGH NUTRITION

New Client Information

Name_____ Date_____
Adress_____
Home#_____ Cell#_____ Work#_____
Email _____ Occupation _____
Referred by _____ How did you hear about us?_____
Age _____ Weight _____ Height _____ Blood Pressure _____
Race _____ Date of birth _____

What is your main area of complaint or interest? _____
_____
How long have you had major complaint listed above? _____

Have you had this or similar complaints in the past? _____

Other complaints: _____

List previous diagnoses and treatments you have received for your present complaint: _____
_____

What do YOU believe is wrong with you? _____

Previous serious illnesses or surgical operations, date and procedure: _____
_____

List all medications you currently take, including prescription, over the counter and vitamins. Include dosage and number taken daily. _____
_____
_____

Wellness Goals

What are your primary health and wellness goals?_____
_____
What are your short term health goals? (6 Mo) _____
_____
What are your long term health goals? (1 yr +) _____
_____
In the past, have you utilized lifestyle and nutritional options to better your health? And if so, what were the results? _____
_____

Are there any obstacles that will make it difficult for you to achieve your goals? _____

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Have you or a family member had any of the following conditions?

CONDITION	Self	Family	CONDITION	Self	Family
Neurological/Mental			**Metabolism**		
Depression	☐	☐	Restless/Hyper	☐	☐
Poor Concentration	☐	☐	Cold tendency	☐	☐
Poor Memory	☐	☐	Cold hands/feet	☐	☐
Moody	☐	☐	Hot tendency	☐	☐
Jittery/shaky	☐	☐	Perspiration	☐	☐
Anger	☐	☐	Night sweats	☐	☐
Worry	☐	☐	Overweight	☐	☐
Headache/migraine	☐	☐	Underweight	☐	☐
Dementia/Alzheimer	☐	☐	Tired after eating	☐	☐
Multiple Sclerosis	☐	☐	Need coffee in a.m.	☐	☐
Fibromyalgia	☐	☐			
Skin and Hair			**Head/Eyes/Nose/Throat**		
Dry	☐	☐	Hay Fever	☐	☐
Rashes	☐	☐	Ringing in ears	☐	☐
Hives	☐	☐	Earaches	☐	☐
Itching	☐	☐	Itching ears	☐	☐
Psoriasis	☐	☐	Sinus problems	☐	☐
Bruising	☐	☐	Runny nose	☐	☐
Hair loss	☐	☐	Post-nasal drip	☐	☐
Dark/swell under eye	☐	☐	Poor sense of taste	☐	☐
Brittle nails	☐	☐	TMJ	☐	☐
			Cold sores	☐	☐
Respiratory			**Cardiovascular**		
Cough/phlegm	☐	☐	Chest pain	☐	☐
Asthma	☐	☐	High blood pressure	☐	☐
Smoke	☐	☐	High cholesterol	☐	☐
COPD	☐	☐	High triglycerides	☐	☐
Bronchitis	☐	☐	Lack of exercise	☐	☐
Frequent colds	☐	☐	Rapid pulse	☐	☐
			Heart attack history	☐	☐
			Stroke history	☐	☐
Viral/Bacterial Infections			**Immune Function**		
HIV/AIDS	☐	☐	Slow recovery	☐	☐
Sex. Transm. Disease	☐	☐	Swollen lymph glands	☐	☐
Lyme disease	☐	☐	Slow wound healing	☐	☐
Frequent strep throat	☐	☐	Frequent antibiotics	☐	☐
Herpes	☐	☐	Sore throats	☐	☐
			Childhood vaccines	☐	☐
			History of shingles	☐	☐

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CONDITION	Self	Family	CONDITION	Self	Family
Gastrointestinal					
Excessive thirst	☐	☐	Heartburn	☐	☐
Low or high appetite	☐	☐	Hemorrhoids	☐	☐
Bloating/gas	☐	☐	Itching in rectum	☐	☐
Constipation	☐	☐	Fatigue after eating	☐	☐
Loose stools	☐	☐	History of gallstones	☐	☐
Mucous in stools	☐	☐	History of ulcer	☐	☐
Nausea	☐	☐	Celiac's Disease	☐	☐
Vomiting	☐	☐	IBS/Crohns	☐	☐
Urinary/Genital			**Sleep**		
Frequent yeast inf.	☐	☐	Difficult to fall asleep	☐	☐
Urinary tract inf.	☐	☐	Restless sleep	☐	☐
Urinary incontinence	☐	☐	Waking up at night	☐	☐
Kidney disease	☐	☐	# times_____		
Frequent urination	☐	☐	Need > 9 hours?	☐	☐
Pain while urinating	☐	☐			
Bed wetting	☐	☐			
Flank/kidney pain	☐	☐			
History of stones	☐	☐			
Muscular/Skeletal/Joint			**Endocrine**		
Joint pain	☐	☐	Diabetes Mellitus T1	☐	☐
Stiffness/swelling	☐	☐	Diabetes Mellitus T2	☐	☐
Muscle spasms	☐	☐	Metabolic Syndrome	☐	☐
Arthritis	☐	☐	Hyperglycemia	☐	☐
Tendinitis/bursitis	☐	☐	Hypoglycemia	☐	☐
Osteoporosis	☐	☐	Thyroid disorder	☐	☐
			Adrenal disorder	☐	☐
Other Conditions					
Food Allergy/Sens.	☐	☐	Chronic Fatigue	☐	☐
Seasonal allergy	☐	☐	Alopecia	☐	☐
Chemical sensit.	☐	☐	Female - hair on face	☐	☐
Anemia	☐	☐	Dental problems	☐	☐
Blood condition	☐	☐	Dizziness	☐	☐
Alcohol/Subst abuse	☐	☐	Low blood pressure	☐	☐
Epilepsy/Seizures	☐	☐	Hepatitis	☐	☐
Eating disorders	☐	☐	Cirrhosis	☐	☐
Gout	☐	☐			

Glasses of water consumed per day? _____ Alcohol per day/week/month_____

Other beverages consumed and amounts per day _____

CONDITION	Self	Family	CONDITION	Self	Family
Women Only					
Premenstrual Symptoms			**Menstrual Symptoms**		
Mood changes	☐	☐	Irregular cycle	☐	☐
Weight gain	☐	☐	Cycle < 28 days	☐	☐
Water retention	☐	☐	Cycle > 28 days	☐	☐
Bloating	☐	☐	Light Menses	☐	☐
Headaches	☐	☐	Heavy Menses	☐	☐
Breast tenderness	☐	☐	Cramping	☐	☐
Low backache	☐	☐	Long Menses>5 days	☐	☐
Acne	☐	☐	Short Menses <5 days	☐	☐
Cravings	☐	☐	Abnormal bleeding	☐	☐
Other Female Issues			**Men only**		
Birth control pills	☐	☐	Impotence	☐	☐
Low sex drive	☐	☐	Prostate enlarged	☐	☐
Infertility	☐	☐			
Family breast cancer	☐	☐			

Accidents/Injuries _____

List any food aversions and/or cravings:_____

Are you under a lot of stress? _____ If yes, home/work/physical/mental ?

Urine color or odor? _____ How many times do you urinate per day? _____

How often do you have bowel movements? _____per day/week/month

Average hours sleep per night: _____

Do you have any negative or positive emotional issues with food now or in the past? If so, what?

_____

Are you experienced with grocery shopping and cooking? _____

Are you willing or able to change grocery and cooking habits if necessary? _____

Do you have dietary or religious restrictions? (vegan, kosher, GF etc)? _____

Is there anything else about your health or history that you feel is important to mention?

Please complete a 24 hour food recall. Use the following as an example.

TIME	PLACE	MEAL	FOOD/BEVERAGE ITEM	DETAILS/INGREDIENTS	AMOUNT
8am	home	bkfast	Oatmeal	Made with water, butter, salt	1 cup
			Coffee	2 T cream, 1 Tsp sugar	1 cup
			strawberries		1 cup
12pm	restaurant		Pizza	cheese, 2 slices	
		Lunch	Salad	veggies with dressing	2 cups
			1 glass water		2 T dressing

Name:

TIME	PLACE	MEAL	FOOD/BEVERAGE ITEM- including water	DETAILS/INGREDIENTS	AMOUNT

TIME	PLACE	MEAL	FOOD/BEVERAGE ITEM- including water	DETAILS/INGREDIENTS	AMOUNT