Nutrition and Health Intake Form

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Name_____ Telephone Number(s) _____ Date_____

Emergency Contact _____ Relation _____ Phone _____

Address_____

Birthdate _____ Email _____ Children? _____ How Many? _____

(Circle) Gender: M/F Marital Status: Single Single-Parent Married Divorced Widowed

How did you hear about us? _____

→*Do You Wish to Receive Bi-Monthly Wellness Education Center via email Events & Classes (Yes/No)*

Top concerns for Health (In Order of Importance)

1) _____
2) _____
3) _____
4) _____
5) _____

Past Medical History/Surgeries/Hospitalizations & Dates (At least past 2 years)

_____
_____
_____
_____
_____

Other Health Care Providers (Medical Doctor/Naturopath/Chiropractor/Acupuncture/Dental/Herbal/Biofeedback, etc.)

_____
_____

Last Physical _____

Pertinent Labs/Scans/Tests (may attach separately, please bring in any labs or have doctor fax to 755-8432)

_____
_____
_____

Family History of Disease (ex. Heart, Cancer, Mental Illness, Diabetes, Stroke, Cholesterol, auto-immune)

_____
_____
_____
_____

Allergies (Medication/Food/Environment) & Reactions

_____
_____
_____
_____

Nutritional/Vitamins/Herbal/Essential Oil/Homeopathic Supplements

_____

_____

_____

_____

_____

Regular Use of (Circle)

Antacids (Type_____) Tylenol/Acetaminophen Anti-Yeast/Fungal

Laxatives (Type_____) Birth Control Pills Aspirin

Stool Softeners Antibiotics

Anti-Inflammatories (Ibuprofen, Aleve, Advil, Motrin, prescription)

List Other Over the Counter Medications (& how often)

_____

_____

_____

Prescription Medications

_____

_____

_____

_____

How Motivated are you to change Nutrition, Habits & Lifestyle to be Well?? _____

Dietary Preferences

How much water do you drink a day? ____ oz./glasses/liters Water Type: Bottled, City, Filtered, or Well?

Do you eat breakfast? _____ Do You Eat for Hunger or Emotions? _____

Diet Preferences: Standard American Diet Organic (Yes/No) Vegetarian Vegan Paleo

Adkins Ketogenic High Protein Whole Foods Auto-Immune Living Foods Gluten, Soy or Dairy Free

Prepare your meals at home (___ %) vs. eating out (___%) Where do you eat out? _____

Estimate Percentage of Processed Food Consumption (Fast Food, Packaged Food in Box, Bag, Can) __%

Estimate Percentages of Diet Animal (meat/dairy/eggs) ____ % vs. Plant ____% Based Foods

What are your sources of protein? Meat Dairy Protein Powders (type_____) Nuts/Seeds

Eggs Beans Whole Grains Vegetables/Plants

If/What Animal Protein Types (Circle all that Apply)? Organic (Yes/No) Pork Buffalo

Eggs (Organic /Conventional) Wild Game Chicken/Turkey (Conventional or Free Range)

Beef (Conventional or Grass Fed) Fish (list types_____) Other: _____

Do you consume cow/goat dairy? _____ How Much? _____ oz/servings

What types? Cheese Milk Creamer Ice Cream Cottage Cheese Yogurt/Kefir

How much meat/dairy/eggs/animal proteins do you consume daily? ____oz., _____gm. or ____ servings

If you know, What would you think your dietary percentages consumed?

___ % Carbohydrates (Vegetables, Fruits, Legumes, Whole Grains [Breads, Pasta, Rice])

___ % Protein (Vegetables, Legumes, Whole Grains, Meat, Dairy, Eggs)

___ % Fats (Oils, Nuts, Avocados, Seeds, Meat, Dairy, Eggs)

___ % Dessert/Sugar Foods/Refined Grains [white rice, pasta, white breads, white flour]

Circle What You Consume in your Regular Diet/Lifestyle

Alcohol: Wine Beer Liquor How Much? ____day/week

Sweetness: Sugar Honey Maple Syrup Xylitol Stevia Truvia Splenda (Sucralose) Ace-Sulfame K
Aspartame (NutraSweet/Sweet N Low/Equal) Splenda (Sucralose) High Fructose Corn Syrup
Comments or How much in a day? _____
Pastry Cookie Candy Cake Donut Ice Cream How often?_____ per day/week

Saltiness: Sea Salt Iodonized Salt MSG & similar Alpine Touch Herbs

Cooking Style: ___% Uncooked/Raw ____ % Cooked Microwave Fried Foods

Oils/Fats: Shortening Crisco Margarine Butter/Ghee Olive Vegetable Grapeseed
Canola Corn Sunflower Safflower Soy Peanut Earth Balance
Avocado Oil Hemp Flaxseed Cottonseed Fish Krill Cod Liver
Avocados Chia Roasted Nuts/Seeds Raw Nuts/Seeds Other: _____
Salad Dressing? List favorites _____

Beverages: Soda Sparkling Water Coffee (Regular or Decaf?) Regular Tea Green Tea
Mate Herbal Tea Crystal Light Fruit Juice Vegetable Juice Vitamin Water

Ferments: Sauerkraut/Kimchi Yogurt/Kefir Kombucha Kevita Probiotics

List Your Normal Foods for Each Meal

Breakfast _____
_____

Lunch _____
_____

Dinner _____
_____

Snacks _____

Eating Habits

Typical Meal Portion Size? _____ (can express in fist size) Feel like you under eat/overeat?

How many hours between your dinner/snack and bedtime? _____ Hours

Do You Chew Your Food Well or Inhale/Swallow Like a Snake?? _____

Do you sit down to eat meals or eat on the go? _____

What foods are difficult for you to digest (Indigestion, gas, bloating, slow to digest) _____
_____

List any known food intolerances _____
_____

Are you interested in food intolerance/allergy testing due to digestive issues? _____

Favorite Foods _____
_____
_____

What foods do you crave the most? _____
_____
_____

What are unhealthy foods you have a weakness for and need a healthier substitution? _____
_____
_____

Lifestyle

Exercise? _____ Type(s) _____

How Often _____ Occupation _____ Hours/week _____

Biggest Source of Stress? _____

How do you De-Stress? _____

Spiritual Practice (optional)? _____

Sleep: _____ hours/night If you Wake up Frequently, why? _____

Height _____ Optimal Weight _____ lb. Current Weight _____ lb.

Unresolved Emotions (Circle)

Anger Unforgiveness Abuse Neglect Stress Fear Grief Hopeless Anxiety Depression Other_____

Toxicity/Exposure (Circle/fill in)

Long Term Exposure to Solvents/Paints/Beauty Salon/Chemicals/Herbicides/Pesticides? _____

Exposure to Round-up (Glyphosate)? Chemotherapy? Eat GMO Foods? Swim in Pool/Hot Tub?

Eat/store/cook/freeze in plastics? _____ Metallic Taste in Mouth? _____ Radiation Exposure?

Metal Exposure: Mercury _____ Lead _____ Aluminum _____ Fluoride _____ Other _____

Aluminum Cookware Aluminum in Antiperspirant Dry Clean Clothes

Silver Dental Fillings Current # ____ # Removed _____ When _____ Root Canals? _____

Unhealthy Teeth/Gums/Gum Disease? Describe _____

Mold exposure in your home/work? _____ New House or Office Building in the Last 5 years? _____

Other Toxicity or Exposures?? _____

Review of Symptoms (You may circle word or give it severity/frequency ranking)

0=never 1=Mild/Rarely/Monthly 2=Moderate/Occasionally/Weekly 3=Severe/Frequently/Daily P=Past/No longer present

Nutrients

Tongue Issues	0 1 2 3 P	Itchy Skin	0 1 2 3 P
Cracked Corners of Lips	0 1 2 3 P	Skin Issues _____	0 1 2 3 P
Poor Dream Recall	0 1 2 3 P	Nail Issues, Spots or Ridges	0 1 2 3 P
Leg Cramps	0 1 2 3 P	Poor Taste/Smell	0 1 2 3 P
Restless Legs	0 1 2 3 P	Poor wound/cut Healing	0 1 2 3 P
Crave Ice/Crunching	0 1 2 3 P	Osteoporosis/Osteopenia	0 1 2 3 P
Dry Skin	0 1 2 3 P	Cracking/Popping Joints	0 1 2 3 P

Blood Sugar & Metabolism

Crave Sugar or Carbohydrates	0 1 2 3 P	Excess Thirst	0 1 2 3 P
Low Blood Sugar	0 1 2 3 P	Fatigue after sugar	0 1 2 3 P
Shaky or jittery if skipped meal	0 1 2 3 P	Darkening of Skin Folds	0 1 2 3 P
Hungry Often/Snack Frequently	0 1 2 3 P	Bloating after sugar	0 1 2 3 P
Wake up after falling asleep	0 1 2 3 P	Insulin Resistance	0 1 2 3 P
Excess Appetite	0 1 2 3 P	Gestational Diabetes	0 1 2 3 P
Loss of Appetite	0 1 2 3 P	Children over 9lb @ birth?	Yes/No
Eating relieves Fatigue or Irritability	0 1 2 3 P	Diabetes/Pre-diabetes Diagnosis	0 1 2 3 P
Frequent/Excess Urination	0 1 2 3 P	HgA1C? _____	

Immunity

How often do you get colds/year? _____/yr.

How often do you get flu/year? _____/yr.

Other infections? _____ _____/yr.

_____

Optional History (Circle:) Epstein Barr/Mono CMV

Shingles Herpes Cold Sores Canker Sores

Last Vitamin D Level _____ Date _____

Take Vitamin D daily? _____ iu

Cardiovascular/Blood

Chest Pains/Angina	0 1 2 3 P		Elevated Cholesterol	0 1 2 3 P
Heart Palpitations/Arrhythmias	0 1 2 3 P		Metabolic Syndrome	0 1 2 3 P
Enlarged Heart/Tired Heart	0 1 2 3 P		Varicose Veins	0 1 2 3 P
Ankles or Hands Swell	0 1 2 3 P		Bruise Easily	0 1 2 3 P
Shortness of Breath with exertion	0 1 2 3 P		Bleed Easily	0 1 2 3 P
High Altitude Discomfort	0 1 2 3 P		Poor Wound Healing	0 1 2 3 P
High Blood Pressure	0 1 2 3 P		Anemia Type?? _____	0 1 2 3 P
Low Blood Pressure	0 1 2 3 P		High Iron Levels	0 1 2 3 P
Homocysteine Testing?	Yes/No		Heart Surgery	Yes/No

Respiratory/EENT

Chronic Cough	0 1 2 3 P		Itchy Ears	0 1 2 3 P
Asthma	0 1 2 3 P		Hearing Loss	0 1 2 3 P
Wheezing	0 1 2 3 P		Ear Infections	0 1 2 3 P
Shortness of Breath	0 1 2 3 P		Ear Pain	0 1 2 3 P
Coughing up Blood	0 1 2 3 P		Dry Eyes	0 1 2 3 P
Post Nasal Drip	0 1 2 3 P		Watery Eyes	0 1 2 3 P
Sinusitis	0 1 2 3 P		Itchy/Red Eyes	0 1 2 3 P
Sore Throat	0 1 2 3 P		Eye Infections	0 1 2 3 P
Hoarseness	0 1 2 3 P		Vision Changes	0 1 2 3 P
Nasal Drip/Runny Nose	0 1 2 3 P		Poor Night Vision	0 1 2 3 P
Ringing in Ears	0 1 2 3 P			

Endocrine

Enlarge Glands	0 1 2 3 P		Weak Muscles	0 1 2 3 P
Cold Hands and Feet	0 1 2 3 P		Goiter/Swelling @ Neck	0 1 2 3 P
Intolerance to Cold	0 1 2 3 P		Puffy Eyes in AM	0 1 2 3 P
Intolerance to Heat	0 1 2 3 P		High Cholesterol	0 1 2 3 P
Thinning, Course, or Brittle Hair	0 1 2 3 P		Depression	0 1 2 3 P
Thinning Outer Eyebrows	0 1 2 3 P		Anxiety	0 1 2 3 P
Dry Skin	0 1 2 3 P		Insomnia	0 1 2 3 P
Brittle Nails	0 1 2 3 P		Low blood pressure	0 1 2 3 P
Foggy Brain	0 1 2 3 P		Crave salt	0 1 2 3 P
Fatigued All Day/Night	0 1 2 3 P		Excessive Stress	0 1 2 3 P
Fatigued AM, best after 10am	0 1 2 3 P		Feel overcommitted	0 1 2 3 P
Tend to be a "night" person	0 1 2 3 P		Anxious or Nervous	0 1 2 3 P
Trouble getting to sleep (wired)	0 1 2 3 P		Feel Energized with Exercise	0 1 2 3 P
Difficulty Losing Weight	0 1 2 3 P		Feel Fatigued with Exercise	0 1 2 3 P
Weight Gain Around Middle	0 1 2 3 P		Dizziness upon standing	0 1 2 3 P
Constipation	0 1 2 3 P		Need coffee/caffeine to get going	0 1 2 3 P

Bladder/Kidney

Kidney Stones	0 1 2 3 P		Burning with Urination	0 1 2 3 P
Frequent Urination	0 1 2 3 P		Urinary Tract Infection	0 1 2 3 P
Incontinence/Dribbling	0 1 2 3 P		Blood in Urine	0 1 2 3 P
Cloudy, bloody urine	0 1 2 3 P		Bubbles in Urine	0 1 2 3 P
Urine has Strong Odor	0 1 2 3 P		Urination during the night	0 1 2 3 P

Muscle/Skeletal

Joint Pain	0 1 2 3 P		Gout	0 1 2 3 P
Joint Swelling/Stiffness	0 1 2 3 P		Back Pain	0 1 2 3 P
Which ones?_____			Numbness or Tingling extremities	0 1 2 3 P
Muscle Weakness	0 1 2 3 P		Area(s)_____	
Muscle Pain	0 1 2 3 P		Injuries	0 1 2 3 P
Fibromyalgia	0 1 2 3 P		Area(s)_____	

Liver/Gallbladder

Intolerance to greasy foods	0 1 2 3 P	History of Drug or Alcohol Abuse	0 1 2 3 P
Pain under right ribcage	0 1 2 3 P	History of Hepatitis	0 1 2 3 P
Pale, Yellow or Gold Stool	0 1 2 3 P	Sensitive to Chemicals, Perfumes, Cleaning Agents,	
Skin rashes or disturbances	0 1 2 3 P	Tobacco, Diesel Fumes	0 1 2 3 P
Dark Urine	0 1 2 3 P	Sweat Profusely	0 1 2 3 P
Gallbladder attacks	0 1 2 3 P	Hot Flashes ~2-4am	0 1 2 3 P
Easily hung over if you have wine	0 1 2 3 P		

Digestion *(Optional: Ask for Comprehensive Digestive Health Assessment or download @ www.kimfedderly.com if unresolved Digestive Issues)*

Stool Consistency: Normal/Soft like a Banana, Hard/Pebbles, Floating, Mucous, Oily, Blood, Loose/Watery, Irritable Bowel

Bowel Movements	_____/day or week	Food Sensitivities	0 1 2 3 P
Is food undigested in Stool?	Yes/No	Lactose Intolerance	0 1 2 3 P
GERD/Acid Reflux	0 1 2 3 P	Celiac or Gluten Intolerance	0 1 2 3 P
Stomach Ulcers	0 1 2 3 P	Eczema/Dermatitis/Psoriasis	0 1 2 3 P
Stomach Pain	0 1 2 3 P	Rosacea	0 1 2 3 P
Burping after Meals	0 1 2 3 P	Diverticulitis	0 1 2 3 P
Bloating	0 1 2 3 P	Teeth Grinding	0 1 2 3 P
Gas	0 1 2 3 P	Gas/Bloating worsened with sugar	0 1 2 3 P
Nausea	0 1 2 3 P	Feel bad with grains/starches	0 1 2 3 P
Vomiting	0 1 2 3 P	Foggy Brain with grain/sugar/starch	0 1 2 3 P
Dark Foul Stools	0 1 2 3 P	Probiotics make digestion worse	0 1 2 3 P
Colon Polyps	0 1 2 3 P	Dark Circles Under Eyes	0 1 2 3 P
Hemorrhoids	0 1 2 3 P	White/Yellow Coated Tongue	0 1 2 3 P
Constipation	0 1 2 3 P	Itchy: Ears/Genitals/Anus or Mouth	0 1 2 3 P
Diarrhea	0 1 2 3 P	Acne	0 1 2 3 P
Irritable Bowel Syndrome/Disease	0 1 2 3 P	Hives/Rashes	0 1 2 3 P
Leaky Gut	0 1 2 3 P	Athletes Foot or Fungal Nails	0 1 2 3 P

Nervous System *(Optional: Ask for Comprehensive Anxiety/Depression Symptom Checklist or download from www.kimfedderly.com)*

Memory Loss	0 1 2 3 P	Nervousness	0 1 2 3 P
Confusion	0 1 2 3 P	Head Injury When? _____	0 1 2 3 P
Anxiety	0 1 2 3 P	Seizures	0 1 2 3 P
Depression	0 1 2 3 P	Tremors	0 1 2 3 P
Irritability	0 1 2 3 P	Nerve Injuries	0 1 2 3 P
Insomnia	0 1 2 3 P	Neuropathy	0 1 2 3 P

Female

Vaginal Discharge	0 1 2 3 P	Heavy Periods	0 1 2 3 P
Ovarian Cyst	0 1 2 3 P	Irregular Periods	0 1 2 3 P
Fibrocystic Breast	0 1 2 3 P	Length of Period ___ Days or Menopause	
Breast Pain	0 1 2 3 P	Flow: light medium heavy (circle)	
Breast Lumps	0 1 2 3 P	PMS	0 1 2 3 P
Loss of Sex Drive	0 1 2 3 P	Menstrual Difficulties	0 1 2 3 P
Vaginal Yeast Infections	0 1 2 3 P	Excessive Cramping	0 1 2 3 P
Female Surgery Type ?_____	Yes/No	Hormone Imbalances	0 1 2 3 P

Male

Prostate Problems	0 1 2 3 P	Interruption of urine stream	0 1 2 3 P
Elevated PSA Lab=_____	Yes/No	Testicle Pain	0 1 2 3 P
Decreased Urine Flow	Yes/No	Testicle Lump	0 1 2 3 P
Difficulty with Urination, dribbling	0 1 2 3 P	Loss of Sex Drive	0 1 2 3 P
Difficult to start/stop urine	0 1 2 3 P	Loss of Muscle Strength	0 1 2 3
Waking up to urinate at night	0 1 2 3 P		