Therapeutic Nutrition
For Nutritional Based Healing

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Applying the Science of Nutrition to the
Art of Healing on the Western Slope of Colorado

New Client Intake Form

Please return this form 1 week prior to your appointment date.

All information received on this form will be treated as strictly confidential. Please fill out the form completely and accurately. This information is essential to helping the nutrition therapist develop a wellness program that addresses your needs, goal and interests, while also being safe and effective.

Appointment Date and Time: _____

Name: _____ Date: _____

Address: _____ Date of Birth: _____

_____ Gender: _____

_____

_____

Preferred phone: _____ ☐ Home ☐ Work ☐ Mobile

Secondary phone: _____ ☐ Home ☐ Work ☐ Mobile

Email address: _____

Occupation: _____ Primary Doctor: _____

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

Name: _____ Date of Birth: _____

Medical History					
		Family			Family
GASTROINTESTINAL	You	History	INFLAMMATORY/AUTOIMMUNE	You	History
Irritable Bowel Syndrome			Chronic Fatigue Syndrome		
Inflammatory Bowel Disease			Rheumatoid Arthritis		
Crohn's Disease			Lupus SLE		
Ulcerative Colitis			Frequent Infections		
Celiac Disease			Severe Infectious Disease		
Gastric or Peptic Ulcer Disease			Herpes		
GERD, Reflux / Heartburn			Gout		
Hepatitis C or Liver Disease			Other:		
Food Intolerance					
Other:					
RESPIRATORY			MUSCULOSKELETAL / PAIN		
Asthma			Osteoarthritis		
Chronic Sinusitis			Chronic Pain		
Sleep Apnea			Fibromyalgia		
Bronchitis or Emphysema			Migraines		
Tuberculosis			Other:		
Other:					
CARDIOVASCULAR			URINARY / REPRODUCTIVE		
Heart Disease / Heart Attack			Kidney Stones		
Stroke			Urinary Tract Infections		
Elevated Cholesterol			Yeast Infection		
Irregular Heart Rate			Prostate Problems		
High Blood Pressure			Other:		
Other:					
NEUROLOGICAL / BRAIN			METABOLIC / ENDOCRINE		
Depression			Type 1 Diabetes		
Anxiety			Type 2 Diabetes		
Bipolar Disorder			Metabolic Syndrome		
ADD / ADHD			Hypoglycemia		
Multiple Sclerosis			Hypothyroidism		
Seizures			Hyperthyroidism		
Anorexia Nervosa			Polycystic Ovarian Syndrome		
Bulimia			Infertility		
Unspecified Eating Disorder			Other:		
Parkinson's Disease					
Other:					
DERMATOLOGICAL			CANCER (list types and treatments)		
Eczema					
Psoriasis					
Acne					
Other:					

List any additional health conditions your doctor has diagnosed: _____

_____

_____

_____

Name: _____ Date of Birth: _____

Please list any pervious injuries, surgeries, and hospitalizations. Provide your age or the date at time of surgery, if known. Surgery / Injury / Hospitalization	Age	Date

Do you visit a dentist twice per year? ☐ Yes ☐ No

Do you have any amalgam (silver) filling? ☐ Yes ☐ No How many? _____

Please list any dental work you have had done in the last 5 years: Dental Procedure	Date

When was the last time you were on a course of antibiotics? _____

What were they prescribed for? _____

How many courses of antibiotics have you been on in your lifetime? ☐ 0 to 3 ☐ 4 to 10 ☐ 10+

Describe your job duties _____

_____

_____

Are you regularly exposed to any of the following?

☐ Cigarette smoke ☐ Auto exhaust / fumes ☐ Paint Fumes ☐ Chemicals ☐ Perfumes ☐ Dry-cleaned clothes ☐ Nail Polish ☐ Hair dyes

Do you feel dizzy or get a headache when exposed to strong chemical odors or fumes? ☐ Yes ☐ No

If yes, please explain. _____

_____

Name: _____ Date of Birth: _____

Your Birth History (please check all that apply).							
	Vaginal		C-section		Breast-fed		Bottle-fed
	Full-term		Premature		Pregnancy complications		Birth complications

Do you smoke tobacco now? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

How much do you smoke per day? _____

Do you drink alcohol? ☐ Yes ☐ No What type? _____ How often? _____

Do you use recreational drugs? ☐ Yes ☐ No What type? _____ How often? _____

Do you travel to foreign countries? ☐ Yes ☐ No Wilderness Camping? ☐ Yes ☐ No

Please list all Medications and Supplements you are currently taking:

Medication / Supplements	Dosage	How often?	Reason for use

If more room is needed, please use reverse side of page or attach an additional page.

Allergies (please list all that apply and the symptoms experienced).

Foods	Medications	Supplements	Environmental

Name: _____ Date of Birth: _____

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 your answer is no or almost not at all then wrote 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 point 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 never 1 = Suffer OCCASIONALLY (less than 2 times per week), is not severe 2 = Suffer FREQUENTLY (2 or more times per week), is not severe 3 = Suffer OCCASIONALLY and is severe 4 = Suffer FREQUENTLY and is severe	

CONSTITUTIONAL

_____ Fatigue (sluggish, tired)
_____ Hyperactive (nervous energy)
_____ Restlessness (can't relax/sit still)
_____ Sleepiness During Day
_____ Insomnia at Night
_____ Malaise
_____ **Total (0-20)**

EMOTIONAL/MENTAL

_____ Depression (feelings of hopelessness)
_____ Anxiety (vague fears, uneasiness)
_____ Mood Swings (rapid distinct changes)
_____ Irritability
_____ Forgetfulness
_____ Lack of concentration/focus
_____ **Total (0-24)**

HEAD/EARS

_____ Headache (any kind)
_____ Migraine (diagnosed)
_____ Earache
_____ Ringing in Ear
_____ Itchy Ears
_____ **Total (0-24)**

SKIN

_____ Blemishes, Acne
_____ Rashes, Hives
_____ Eczema
_____ "Rosy" Cheeks
_____ **Total (0-16)**

NASAL/SINUS

_____ Post Nasal Drip
_____ Sinus Pain
_____ Runny Nose
_____ Stuffy Nose
_____ Sneezing
_____ **Total (0-20)**

MOUTH/THROAT

_____ Sore Throat
_____ Swollen Throat
_____ Swelling of Lips/Tongue
_____ Gagging/Throat Clearing
_____ Lesions ("Canker Sores")
_____ **Total (0-20)**

LUNGS

_____ Wheezing (Asthma or Asthma-like symptoms)
_____ Chest Congestion
_____ Non-Productive Coughing
_____ Productive Coughing
_____ **Total (0-20)**

EYES

_____ Red or Swollen Eyes
_____ Watery Eyes
_____ Itchy Eyes
_____ Dark Circles or Baggy Eyes
_____ Total (0-16)

GENITOURINARY

_____ Increased Urinary Frequency
_____ Painful Urination
_____ **Total (0-8)**

MUSCULOSKELETAL

_____ Joint Pains/Aching
_____ Stiff Joints
_____ Muscle Aches
_____ Stiff Muscles
_____ **Total (0-20)**

CARDIOVASCULAR

_____ Irregular Heartbeat
_____ High Blood Pressure
_____ **Total (0-8)**

DIGESTIVE

_____ Heartburn/Esoph.Reflux
_____ Stomach Pains/Cramps
_____ Intestinal Pains/Cramps
_____ Constipation
_____ Diarrhea
_____ Gas (of any kind)
_____ Nausea, Vomiting
_____ Painful Elimination
_____ **Total (0-36)**

WEIGHT MANAGEMENT

_____ Fluctuating Weight
_____ Food Cravings
_____ Water Retention
_____ Binge Eating
_____ Binge Drinking
_____ Purging (all methods)
_____ **Total (0-20)**

Name: _____ Date of Birth: _____

How many hours do you work in a regular work week? _____

Please check all that apply to your usual work environment?

☐	Sitting	☐	Mix of Sitting and walking	☐	Other: (please list)
☐	Lifting / carrying	☐	Florescent lighting		_____
☐	Driving	☐	Computer		_____
☐	Construction / Manual labor	☐	Outside		_____

Do you engage in physical activity on a regular basis? ☐ Yes ☐ No If yes, complete the table below.

Activity	Number of Days per Week	Duration (minutes) per Session

How many hours do you sleep on weeknights? ☐ <6 ☐ 6 - 8 ☐ 8 – 10 ☐ 10+

How many hours do you sleep on weekends? ☐ <6 ☐ 6 - 8 ☐ 8 – 10 ☐ 10+

What is your usual bedtime? _____ What time do you usually rise? _____

How well do you sleep? _____ Do you use an alarm to wake up? _____

Check all that apply: ☐ Trouble falling asleep ☐ Wake up during the night ☐ Don't feel rested

On a scale of 1 – 10 (10 being the most stressed), how stressed are you? _____

List your stressors: _____

_____

How do you handle stress? _____

_____

What helps you relax? _____

_____

How would you describe your health in general? _____

_____

Name: _____ Date of Birth: _____

Have you ever visited with a dietitian or nutritionist in the past? ☐ Y ☐ N Please describe.

Have you ever changed your eating habits for a health reason? ☐ Y ☐ N Please describe.

Do you avoid any particular foods? ☐ Y ☐ N Please explain.

Have you recently lost or gained weight? ☐ Y ☐ N If yes, please describe.

Do you drink caffeinated beverages (coffee/tea)? ☐ Y ☐ N If yes, how many cups per day?

Do you drink carbonated sodas? ☐ Y ☐ N If yes, how may ounces per day?

Do you use artificial sweeteners? ☐ Y ☐ N If yes, what kind?

Do you eat and work simultaneously? ☐ Y ☐ N

Do you eat alone? ☐ Y ☐ N

Do you eat while driving? ☐ Y ☐ N

How much water do you drink daily? _____ From the Tap? ☐ Y ☐ N If no, please explain.

How many meals do you eat each day? _____

How many snacks do you eat each day? _____

Where do you usually shop for food? _____

What is your favorite meal of the day? _____

What is your weekly budget for food? _____

How many members in your household? _____

What is your current height? _____

What is your current weight? _____

What is your usual weight? _____

What is your desired weight? _____

On a scale of 1 thru 10 (10 being most willing) rate your willingness to make the following suggested changes to achieve your health goals:

Your will to change your diet / eating habits? _____

Your will to practice relaxation techniques? ____

Your will to take several supplements per day? _____

Your will to engage in regular exercise / movement? _____

Your will to have lab tests done to track progress? _____

Your will to keep a daily record of what you eat & drink? _____

Your will to modify lifestyle (e.g., sleep or work patterns). _____

Name: _____ Date of Birth: _____

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

☐ Love to eat	☐ Fast eater	☐ Live alone or eat alone often
☐ Love to cook	☐ Erratic eating patterns	☐ Do not plan meals or menus
☐ Emotional eater	☐ Eat too much	☐ Time constraints
☐ Late night eater	☐ Rely on convenience foods	☐ Travel frequently
☐ Struggle with eating issues	☐ Eat fast food frequently	☐ Eat only because I have to (necessity)
☐ Make poor snack choices	☐ Dislike healthy food	☐ Negative relationship with food
☐ Dislike cooking	☐ Don't know how to cook	☐ Family members dictate food choices
☐ No joy in eating	☐ Hungry all of the time	☐ Confused about food/nutrition
☐ Forget to eat	☐ Eat out of boredom	☐ Love well prepared food
☐ Healthy eating habits	☐ I eat just enough	☐ Don't know when to stop eating

If you currently follow a special diet or nutritional program please check all that apply:

☐ Low fat	☐ Low carbohydrate	☐ High protein
☐ Low sodium	☐ Diabetic	☐ No dairy
☐ No wheat	☐ Gluten restricted	☐ Gluten-free
☐ No Grains	☐ Vegetarian	☐ Vegan

Other special Diet: (please describe)

Specific Weight loss program: (please describe)

List 10 of your favorite foods.

List foods that you absolutely will not eat.

List foods that you crave.

Name: _____ Date of Birth: _____

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, hemp seed milk)						
Red meat						
Pork (pork loin, pork roast, pork chops, barbecue)						
Processed meat (sausage, bacon, lunch meat)						
Chicken						
Eggs						
Cold water fish (indicate type:						
Shell fish (indicate type:						
Beans, legumes						
Whole soy foods						
Tofu, tempeh						
Soy "meat alternative" (tofurkey, soy sausage, soy bacon)						
Cruciferous vegetables (cabbage, broccoli, Brussel sprouts)						
Green leafy vegetables (spinach, kale, collards, greens)						
Yellow fruits and vegetables (corn, yellow peppers)						
Other Green fruits and vegetables (peas, avocado, cucumbers)						
Blue / purple fruits and vegetables (berries, prunes, beets)						
Red fruits and vegetables (cherries, apples, tomatoes)						
Orange fruits and vegetables (oranges, carrots, cantaloupe)						
White/tan fruits and vegetables (onions, garlic, ginger)						
Turmeric, cumin, ginger, rosemary, oregano, parsley						
Nuts (indicate type:						
Nut butters (indicate type:						
Healthy cooking oils (extra virgin olive oil, coconut oil)						
Vegetable oil (corn, sunflower, safflower, etc. but not olive oil)						
Butter, ghee						
White Rice, white Pasta, White Bread						
Bagels						
English muffins						
Pancakes or waffles						
Buttermilk biscuits						
Chips (indicate type:						
Pretzels						
Popcorn						
Other snack foods (crackers, goldfish)						
100% whole wheat, rye, barley (whole wheat bread and pasta)						
Other whole grains (millet, quinoa, flax, oats, brown rice)						
Ice cream						
Pastries, cookies, cakes						
Juice (indicate type:						
Punch, lemonade, or sweet tea						
Diet soda						
Soda (not diet)						
Red wine						
Tea (white, green, black)						

Name: _____ Date of Birth: _____

Please answer the following questions to the best of your ability.	True	False	Other
My appetite at breakfast is strong			
My appetite at lunch is strong			
My appetite at dinner is strong			
Going without food for four or more hours is uncomfortable			
I often get hungry and need to snack between meals			
I live to eat, rather than eat to live			
My cravings lean more towards meat and fat than carbohhydrates (not including sugar)			
Vegetarian meals are not satisfactory to me			
Eating meat or fatty food restores my energy			
I prefer salty and or fatty foods to sweet foods			
Fruits alone generally do not satisfy me			
Fasting is very difficult for me			
Eating before bedtime improves the quality of my sleep			
Orange juice in the morning does not agree with me			
Coffee tends to make me feel wired and jittery			
My eyes and/or nose tend to be moist			
I need to urinate often during the day			
I prefer to sleep in, in the morning			
If I cuf myself, the wound heals quickly			
I have daily bowel movements			
My bowel movements are easily passed			
I feel that I digest my meals well			
I feel bloated after meals			
I crave sugary foods			

What is your time frame for achieving your nutrition or health goals?_____

When was the last time you remember feeling really well? _____

_____

Did something trigger the change in your health?_____

_____

_____

What makes you feel worse? _____

_____

What makes you feel better? _____

_____

Referred by (Where did you hear about this service?): _____

Name: _____ Date of Birth: _____

Food Diary: Please record everything that you eat and drink for three days. Include all beverages, cream and sugar added to beverages, condiments added to foods such as salad dressings or spices, candies and gum, also include supplements and medications. Basically everything you ingest for the next three days. Also track when you awake each day and when you go to sleep each day.

Time	Food / Beverage Items (or awake / sleep times)	Amount (cups, oz, tsp)	Location (Home/Away)

Name: _____ Date of Birth: _____

Food Diary: Please record everything that you eat and drink for three days. Include all beverages, cream and sugar added to beverages, condiments added to foods such as salad dressings or spices, candies and gum, also include supplements and medications. Basically everything you ingest for the next three days. Also track when you awake each day and when you go to sleep each day.

Time	Food / Beverage Items (or awake / bedtime)	Amount (cups, oz, tsp)	Location (Home/Away)

***** Reminder *****

Return this intake form to the nutritionist

1 week prior to your appointment date.

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Thank You