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CHIROPRACTIC

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Nutritional Coaching and Wellness

Whole-Food Nutrition

Medical Nutrition Therapy – New Client Intake Form

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 to develop a wellness program that safely and effectively addresses your needs, goals, and interests.

Appointment Date and Time: _____

Referring Physician: _____

DEMOGRAPHICS

Full Name: _____ Preferred name: _____

Date of Birth: _____ Age: _____ Gender: _____

Mailing Address: _____

_____

Preferred Phone #: _____ (home/work/cell)

Secondary Phone #: _____ (home/work/cell)

E-mail Address: _____

CONCERNS

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

1.
2.
3.

FAMILY HISTORY

Have any of your close relatives (parent, sibling, child, grandparent) been diagnosed with the following? Please describe, and provide age of onset for all that apply?

Condition	Family member(s)	Age of Onset	Description
Heart Disease			
High Blood Pressure			
Stroke			
Diabetes			
Cancer			
Overweight			
Food Intolerance			

Autoimmune Disease			

MEDICAL HISTORY Please check the health conditions diagnosed by a physician.

- o Irritable Bowel Syndrome
- o Inflammatory Bowel Disease
- o Celiac Disease
- o Gastric or Peptic Ulcer Disease
- o GERD, reflux/heartburn
- o Hepatitis C or Liver Disease
- o Food Intolerance
- o Chronic Fatigue Syndrome
- o Rheumatoid Arthritis
- o Lupus SLE
- o Frequent Infections
- o Severe Infectious Disease
- o Herpes
- o Gout
- o Asthma
- o Chronic Sinusitis
- o Sleep Apnea
- o Bronchitis or Emphysema
- o Tuberculosis
- o Heart Disease/Heart Attack
- o Stroke
- o Elevated Cholesterol
- o Irregular Heart Rate
- o High Blood Pressure
- o Depression
- o Anxiety
- o Bipolar Disorder
- o ADD/ADHD
- o Multiple Sclerosis
- o Seizures
- o Crohn's Disease
- o Ulcerative Colitis
- o Parkinson's Disease
- o Anorexia Nervosa
- o Bulimia
- o Unspecified Eating Disorder
- o Binge Eating Disorder
- o Eczema
- o Psoriasis
- o Acne
- o Osteoarthritis
- o Chronic Pain
- o Fibromyalgia
- o Migraines
- o Kidney Stones
- o Urinary Tract Infections
- o Yeast Infection
- o Prostate Problem
- o Type 1 Diabetes
- o Type 2 Diabetes
- o Metabolic Syndrome
- o Hypoglycemia
- o Hypothyroidism
- o Hyperthyroidism
- o Polycystic Ovarian Syndrome
- o Infertility
- o Cancer (Please list type(s) and treatment

_____

_____

Additional health conditions your doctor has diagnosed: _____

_____

PREVIOUS SURGERIES: Please list operation and date if known

_____

_____

ALLERGIES

FOOD: _____

MEDICATION: _____

SUPPLEMENT: _____

ENVIRONMENTAL: _____

MEDICATIONS & SUPPLEMENTS

Please list all prescription medications, nutritional supplements, and herbs/botanicals that you are currently taking.

Medication Name	Dose	Frequency	Reason

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc…), Motrin, Aspirin? Y / N

Have you had prolonged or regular use of Tylenol? Y / N

Have you had prolonged or regular use of acid-blocking drugs (Zantac, Pepcid, etc…)? Y / N

Have you taken antibiotics more than 3 times per year? Y / N

Have you been on antibiotics long-term (more than 1 month continuously)? Y / N

LIFESTYLE INFORMATION

How often do you regularly engage in physical activity per week? _____

Please describe the activity and how long the duration (in minutes) per session:

_____

_____

How many hours do you sleep on weeknights? _____ Weekends? _____

Trouble falling asleep? Y / N Wake up during the night? Y / N Feel rested? Y / N

How do you handle stress? What helps you relax?

_____

_____

What is your occupation? _____

NUTRITION HISTORY

Height: _____ Current Weight: _____ Usual Weight Range: _____ Desired Weight: _____

Have you ever had an appointment with a dietitian/nutritionist before? Y / N

Have you changed your eating habits for a health reason? If so, please describe:

_____

_____

Are you currently following a particular eating pattern or nutrition plan? If so, please describe:

_____

_____

Do you avoid any particular foods? If so, please explain: _____

_____

Have you recently lost or gained any weight? Please describe: _____

_____

How many meals do you eat each day? _____ Snacks? _____

NUTRITION HISTORY (continued)

How many times a week do you eat at a sit-down restaurant? _____

How many times a week do you eat fast food? _____

Cups per day of caffeinated beverages consumed (coffee, tea, soda, energy drinks): _____

Do you use any natural or artificial sweeteners? If so, which ones? _____

What is your favorite meal? _____

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

- o Love to eat
- o Love to cook
- o Emotional eater
- o Late night eater
- o Struggle with eating issues
- o Family members have different tastes
- o Dislike cooking
- o Fast eater
- o Erratic eating patterns
- o Eat too much
- o Rely on convenience foods
- o Eat fast food frequently
- o Make poor snack choices
- o Confused about food/nutrition
- o Live alone or eat alone often
- o Do not plan meals or menus
- o Time constraints
- o Travel frequently
- o Eat only because I have to
- o Negative relationship with food
- o Dislike healthy foods
- o Do not know how to cook

FOOD DIARY: Please record what you eat and drink during one typical day (24 hour period) below.

Please include all beverages, cream and sweeteners added to beverages, and condiments added to food.

Time woke up: _____ Bedtime: _____

Time	Food/Beverage Items	Amount (ex: cups, oz. tsp)	Location (home/away)

FOOD-FREQUENCY QUESTIONNAIRE

FOOD	EVERY DAY (ALWAYS)	3 OR 4 TIMES/WEEK (OFTEN)	EVERY 2 OR 3 WEEKS (SOMETIMES)	DON'T EAT (NEVER)
Dairy Products				
Milk, whole				
Milk, reduced fat				
Milk, nonfat				
Cottage cheese				
Cream cheese				
Other cheeses				
Yogurt				
Ice cream				
Sherbet				
Puddings				
Margarine				
Butter				
Other				
Meats				
Beef, hamburger				
Poultry				
Pork, ham				
Bacon, sausage				
Cold cuts, hot dogs				
Other				
Fish				
Canned tuna				
Breaded fish				
Fresh or frozen fish				
Eggs				
Peanut butter				
Grain products				
Bread, white				
Bread, whole wheat				
Rolls, muffins				
Pancakes, waffles				
Bagels				
Pasta, spaghetti				
Pasta, macaroni and cheese				
Rice				
Crackers				
Other				

Continued on next page

FOOD	EVERY DAY (ALWAYS)	3 OR 4 TIMES/WEEK (OFTEN)	EVERY 2 OR 3 WEEKS (SOMETIMES)	DON'T EAT (NEVER)
Cereals				
Sugar-coated				
High-fiber (bran)				
Natural (granola)				
Plain (e.g., Cheerios®)				
Fortified				
Other				
Fruits				
Oranges, orange juice				
Tomatoes, tomato juice				
Grapefruit, grapefruit juice				
Strawberries				
Cranberry juice				
Apples, apple juice				
Grapes, grape juice				
Fruit drink				
Peaches				
Bananas				
Other				
Vegetables				
Peppers				
Potatoes				
Lettuce				
Broccoli				
Spinach				
Carrots				
Corn				
Squash				
Peas				
Green beans				
Beets				
Other				
Snacks and Sweets				
Chips (potato, corn)				
Pretzels				
Popcorn				
French fries				
Cookies				
Pastries				
Candy				
Sugar, honey, jelly				
Soda, regular				
Soda, diet				
Cocoa				
Other				