

Patient Intake Questionnaire
This information will be kept confidential

DATE ___/___/___ DATE OF BIRTH ___/___/___ e-mail: _____@_____

NAME _____

ADDRESS _____

CITY/STATE _____ ZIP _____

PHONE HOME _____ WORK _____

REFERRED BY: _____

HAVE YOU EVER WORKED WITH A:

Integrative Registered Dietitian/ FMNP Registered Dietitian CCN HERBALIST ND

What would you like to accomplish while working with the nutrition therapist?

1. _____
2. _____
3. _____

What would you like to learn about health and nutrition (i.e., food and/or supplements)

1. _____
2. _____
3. _____

Do you feel comfortable taking supplements if you are properly educated about your specific needs for them (eg vitamins, minerals, herbs, nutraceuticals?) ___Yes ___No **Do you have any problems swallowing pills?** ___Yes ___No

PERSONAL HEALTH INFORMATION: (Please check if indicated)

	Cardiovascular	Muscle, Bone and Joint	Immunity	Women's Health Issues
	Heart disease	Sarcopenia (muscle mass loss)	Cancer	PMS
	Family history <i>prior to age 50</i>	Arthritis: Osteoarthritis Rheumatoid	Family history of Cancer	Polycystic Ovarian Disease
	High blood pressure	Osteoporosis or Osteopaenia	Chronic Fatigue	Ammenorhea menstration stopped)
	High Total cholesterol level	Orthopedic Problem	Upper Respiratory Allergies	Dysmenorhea (painful menstration)
	High LDL-Cholesterol level	Exercise Limitations?	Recurring ear infections	Peri-menopause
	Low HDL-Cholesterol level	Gastrointestinal	Auto-immune (type)	Menopause
	High Triglycerides	IBS	High levels of inflammation (CRP, IL6, or TNF)	Recurring Vaginal yeast infections
	Endocrinology	Crohns	Nervous System	Recurring Urinary Tract Infections
	Diabetes mellitus	Ulcerative Cololitis	Chronic Depression	Men's Health Issues
	Thyroid Disease (type)	GERDS/Heart burn	Mild to moderate anxiety	Benign prostatic hyperplasia
	Adrenal fatigue	Diverticulosis/ Diverticulitis	Bipolar	Bacterial prostatitis
	Metabolic	Chronic Constipation	Insomnia	Other:
	Obesity	Chronic Diarrhea	Headaches: types	
	Metabolic syndrome	Dermatology	Cluster	
	Overweight	Varicose Veins	Miagraines	
	Vision	Spider Veins	Sinus	
	Macular degeneration	Thinning Hair	Tinnitus (ringing in the ears)	
	Night vision	Thinning Skin	Memory loss associated with aging	
	Dry eyes	Acne	Chronic pain	

Weight _____

Height _____

NUTRITION AND EXERCISE HABITS

<i>How many meals do you eat a day? Who prepares the meals?</i>		<i>Please check the answer which most closely describes your NORMAL DAILY activity level. (This activity does not include exercise.)</i>
<i>Do you skip Breakfast, Lunch and/or Dinner regularly?</i>		Mostly sedentary (sit down for 8 hours a day)
<i>% of meals eaten at home</i>		Mildly active-some walking and moving about (sit down for 4-6 hours a day)
<i>% of meals eaten out</i>		Very active-little sitting, a lot of movement
<i>Food Allergies or Intolerances? If so which foods?</i>		Heavy physical activity, lifting and moving heavy objects
<i>Are you in a dietary rut?</i>		<i>Do you exercise regularly?</i>
<i>How much water do you drink per day?</i>		Less than 3 hours a week?
<i>About 1- 2 cups per day</i>		Between 3-6 hours a week
<i>About 4- 6 cups per day</i>		More than 6 hours a week
<i>About 8 cups per day</i>		<i>What type of exercise do you perform regularly?</i>
<i>How many cups (6 oz) of coffee do you drink per day?</i>		Strength Training
<i>Do you eat 2-4 servings of fruits practically every day? List types:</i>		Flexibility
<i>Do you eat 4 or more servings of vegetables practically every day? List types:</i>		Agility
<i>Do you eat organically grown food?</i>		Stamina
<i>Do you eat processed foods (i.e., foods packaged in a box, can or etc) at every meal?</i>		Body Awareness (yoga, tai chi, etc.)
<i>Do you purchase and eat low fat dairy foods daily? Are they organic?</i>		Cardiovascular or Aerobic training
<i>Do you expose yourself to probiotics or cultured milk 2-3 x a week?</i>		Other:
<i>Do eat whole grains daily? How many servings?</i>		<i>What is your perceived exertion level when performing cardiovascular exercise (i.e., 1=light, 3=moderate, light sweat, 6=somewhat hard, 10=very hard)</i>
<i>How often do you eat oily fish like salmon (canned and fresh), trout, fresh tuna, mackerel, herring, sardines, swordfish and bluefish (3-5 oz.) per week</i>		<i>How consistent have you been with the above exercise(s)? _____</i> Number of months Number of years
<i>What types of oils do you use? Do you use margarine and/or butter? How often and what type of margarine?</i>		<i>Do you drink alcohol? If so type and number of drinks per week?</i>
		<i>Do you smoke cigarettes? Have you smoked in the past and quit? How long did you smoke?</i> <i>Do you smoke cigars?</i>

PSYCHOSOCIAL STRENGTHS:

1. *What's the greatest accomplishment you've ever made?*

2. *What's the biggest change you've ever made?*

3. *What is the one talent you have that you are most proud of?*

4. *How do you relax when you are stressed?*

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS AND THE APPROXIMATE DURATION OF TIME TAKING THESE MEDS:

Please bring any NUTRITIONAL SUPPLEMENTS you take into my office for our appointment:

If you have a copy of blood work, please include it with this completed intake form, or have your physician fax your blood work to my office at 985.893.0942.