

# NUTRITION INTAKE HISTORY

Date \_\_\_\_\_

## Patient Information

Patient \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Sex: M  F

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Ext. \_\_\_\_\_ Birthdate \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Patient SS# \_\_\_\_\_

E-Mail \_\_\_\_\_  
 Single  Married  Separated  Divorced  Widowed

Best time and place to reach you \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Work Information

Occupation \_\_\_\_\_ Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Company \_\_\_\_\_ Address \_\_\_\_\_

## Spouse Information

Name \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

I verify that all information within these pages is true and accurate.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Patient's Name - Please print

\_\_\_\_\_  
Date



### Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol - elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

### Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other \_\_\_\_\_

### Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last gynecological exam \_\_\_\_\_
- Mammogram  +  -
- PAP  +  -
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section
- Surgical menopause
- Menopause
- Date of last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval between cycles \_\_\_\_\_ days
- Recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) \_\_\_\_\_

### Family Healthy History

- Arthritis
- Astma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_

### Health Habits

- Tobacco: # per day \_\_\_\_\_
- Alcohol: \_\_\_\_\_
- Wine: # glasses/d or wk \_\_\_\_\_
- Liquor: #oz./d or wk \_\_\_\_\_
- Beer: # glasses/d or wk \_\_\_\_\_
- Caffeine: \_\_\_\_\_
- Coffee: # 6oz. Cup/day \_\_\_\_\_
- Tea: # 6oz. Cup/day \_\_\_\_\_
- Soda: # cans/day \_\_\_\_\_
- Other \_\_\_\_\_
- Water: # glasses/day \_\_\_\_\_

### Exercise

- 5 - 7 days per week
- 3 - 4 days per week
- 1 - 2 days per week
- 45 min or more duration/wk
- 30 - 45 min duration/workout
- Less than 30 min
- Walk
- Run, Jog, jump rope
- Weight-lift
- Swim
- Box
- Yoga
- Other \_\_\_\_\_

### Nutrition & Diet

- Mixed food diet (animal & veg)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- Total calorie restriction
- Specific food restrictions: \_\_\_\_\_
- \_\_\_\_\_
- Other \_\_\_\_\_

### Food Frequency

- Servings per day: \_\_\_\_\_
- Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

### Eating Habits

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly (hungry or not)
- Eat on the run
- Add salt to food

### Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (eg, lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (eg, Phytonutrient blends)
- Liquid meals
- Other \_\_\_\_\_

### Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Feel more motivated
- Be more organized
- Think more clearly; be more focused
- Improve memory
- Do better on tests
- Not be dependent on over-the-counter meds like aspirin, ibuprofen, sleeping aids, etc
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (eg. cancer, heart disease, etc..)