Nutrition Initial Intake

Patient Name_____ Date of birth: _____ Age_____

Preliminary questions

Are you seeking maintenance, wellness, or preventative treatment?

- ❑ Yes
- ❑ No, I have a specific health complaint:

  _____

  _____

Are you interested in meridian therapy?

- ❑ No
- ❑ Yes
- ❑ Maybe, i would like more information

What would you like to gain from this visit?

_____

_____

_____

Have you ever been told by a doctor that you have diabetes?

- ❑ Yes
- ❑ No

What has been your lowest adult weight?

_____ pounds

What has been your highest weight?

_____ pounds

What is your weight goal?

- ❑ Weight loss
- ❑ Weight gain
- ❑ Weight maintenance
- ❑ Other

  _____

Over the past 3 months, on average, how many times per week have you participated in physical activity resulting in an elevated heart rate for at least 30 continuous minutes (i.e. jogging, swimming, speed walking, biking, stair stepping, dancing, etc)?

- ❑ 0
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ I have a disability that prevents me from exercising

How long have you been participating in the above activity?

- ❑ I just started
- ❑ A few weeks
- ❑ 1 month
- ❑ A few months
- ❑ 1 year
- ❑ More than on year
- ❑ Many years

If you participate in physical activity, please list the type(s) and duration of activity. (If none, state none)

_____

_____

How physically active is your daily routine?

- ❑ Sedentary
- ❑ Light
- ❑ Other_____
- ❑ Moderate
- ❑ Heavy

Do you have any kind of physical limitations?

- ❑ Yes
- ❑ No

Do you do the cooking at home?

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ Rarely
- ❑ Never

Do you do the grocery shopping?

- ❑ Yes
- ❑ No

How often do you eat out during a typical week?

- ❑ Daily
- ❑ A few times per week
- ❑ Once a week
- ❑ Never

Where do you typically eat?

_____

_____

Are you allergic or have sensitivities to any foods?

- ❑ Yes

  _____

  _____
- ❑ No
- ❑ I don't know

Are there certain foods you avoid?

- ❏ Yes, the foods listed above
- ❏ Yes, different foods than listed above:

  _____
- ❏ No

Do you eat, drink or use any of the following (check all that apply)?

- ❏ Protein drinks
- ❏ Appetite supressants
- ❏ Coffee
- ❏ Decaf coffee
- ❏ Soda
- ❏ Diet soda
- ❏ Laxatives
- ❏ Margarine
- ❏ Butter
- ❏ Fast foods
- ❏ Fried foods
- ❏ Potato chips
- ❏ Tortilla chips
- ❏ Salt (without tasting)
- ❏ Artificial sweeteners
- ❏ Coffee creamers

Have you ever been told by a doctor to follow a specific nutrition plan (weight loss, diabetic, low cholesterol, etc)?

- ❏ Yes
- ❏ No

Are you currently following a nutrition plan (i.e. diabetic, gluten free, low lactose, low cholesterol, vegetarian, vegan, etc?

- ❏ Yes: _____
- ❏ No

What have been some of your health challenges/obstacles that you have encountered in the past?

- ❏ Limiting sweets/desserts
- ❏ Eating too large of quantities
- ❏ Lack of motivation
- ❏ Limiting high sugar beverages (soda, juice, etc)
- ❏ Emotional eating (stress, upset, happy, etc)
- ❏ Feeling overly hungry
- ❏ Feeling overly thirsty
- ❏ Lack of physical activity
- ❏ Not seeing results with physical activity
- ❏ Eating when not hungry
- ❏ Food cravings
- ❏ Chewing/swallowing
- ❏ Skipping meals
- ❏ Unsure about what to eat
- ❏ Lack of appetite
- ❏ Difficulty with shopping
- ❏ Difficulty with cooking
- ❏ Financial challenges
- ❏ Problem with goal setting

Rate your stress level over the last 90 days.

Low 1 2 3 4 5 6 7 8 9 10 High

Please list any other health symptoms or health complaints you are currently experiencing.

_____
_____
_____

What changes are you ready to make in the next 30-60 days to improve your overall health?

_____
_____
_____

Past Medical History

Please describe your past medical history:

_____
_____

Please list all your current medications and reasons for taking them:

_____
_____

Have you had any lab work done in the past year?

- ❑ Yes
- ❑ No

Is there any chance that you are pregnant?

- ❑ Yes
- ❑ No
- ❑ N/A

Is there any chance you may become pregnant in the next 3 months?

- ❑ Yes
- ❑ No
- ❑ N/A

Is there anything else about your history or current condition that you feel is important to mention?

_____
_____
_____
_____

Social History

Please list vitamins, supplements or herbs you are taking, and the reason for taking them:

_____
_____
_____

I affirm that all of the information on this form is true and accurate according to the best of my knowledge, and I consent to a chiropractic examination and treatment in accordance with this state's statutes.

Patient signature _____ Date _____

Parent/Guardian signature _____ Date _____