# 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

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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 to any foods?

- ❑ Yes
- ❑ No
- ❑ I don't know

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 (blue, pink, or yellow packets)
- ❑ Coffee creamers

Do you have any food intolerance/sensitivities?

- ❑ Yes:
  _____
- ❑ No
- ❑ I don't know

Are there certain foods you avoid?

- ❑ Yes, the foods listed above
- ❑ Yes, different foods than listed above:
  _____
- ❑ No

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:

_____
_____
_____
_____

Please list all of your past surgeries, including estimated dates:

_____
_____
_____
_____

Please list hospitalizations, reasons for them, and approximate dates:

_____
_____
_____
_____

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

Do you smoke?

- ❑ Yes
- ❑ I used to smoke, but I quit
- ❑ I only smoke once in a while
- ❑ I have never smoked
- ❑ I vape

Do you drink alcohol?

- ❑ Yes
- ❑ Yes, socially
- ❑ Yes, but only on weekends
- ❑ No

Do you use recreational drugs?

- ❑ Yes
- ❑ No

How often do you exercise?

- ❑ Daily
- ❑ Several times per week
- ❑ Once in a while
- ❑ Rarely
- ❑ Never

How is your diet?

- ❑ Healthy
- ❑ Sometimes healthy
- ❑ Fast food
- ❑ Other_____

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

_____

_____

_____

Please list your hobbies

_____

_____

Please describe your work activities:

_____

_____

What is your highest level of education?

- ❑ Some high school
- ❑ High school diploma or GED
- ❑ Some college
- ❑ Bachelor Degree
- ❑ Masters Degree
- ❑ Doctorate Degree, PhD, or equivalent
- ❑ Post Doctoral
- ❑ I prefer not to answe

## Family Medical History

Please describe your family history. Please include parents and siblings.
Please list the approximate age at which they were diagnosed, if known.

**Father:**

- ❑ Unknown
- ❑ None
- ❑ Diabetes
- ❑ Cancer (what type) _____
- ❑ Other: _____
- ❑ High blood pressure
- ❑ Heart problems
- ❑ Stroke

*Age of diagnosis:*_____

**Mother:**

- ❑ Unknown
- ❑ None
- ❑ Diabetes
- ❑ Cancer (what type) _____
- ❑ Other: _____
- ❑ High blood pressure
- ❑ Heart problems
- ❑ Stroke

*Age of diagnosis:*_____

**Siblings:**

- ❑ Unknown
- ❑ None
- ❑ Diabetes
- ❑ Cancer (what type) _____
- ❑ Other: _____
- ❑ High blood pressure
- ❑ Heart problems
- ❑ Stroke

*Age of diagnosis:*_____

## Review of systems

***Please check all that apply***

General:

- ❑ Unexplained weight loss
- ❑ Unexplained weight gain
- ❑ Change in sleeping patterns
- ❑ Change in activity levels
- ❑ Cancer
- ❑ None of these

Neurological:

- ❑ Anxiety
- ❑ Headaches
- ❑ Depression
- ❑ Meningitis
- ❑ Paralysis
- ❑ Seizure
- ❑ Tingling
- ❑ Stroke
- ❑ Memory loss
- ❑ Fainting spells
- ❑ Dizziness
- ❑ Head injuries
- ❑ Black outs or near black outs
- ❑ Change in sensation in any part of your body
- ❑ Localized weakness or numbness
- ❑ None of these

Eyes, ears, nose, throat:

- ❑ Hay fever
- ❑ Glaucoma
- ❑ Polyps
- ❑ Allergies
- ❑ Cataracts
- ❑ Goiter
- ❑ Hoarseness
- ❑ Gum problems
- ❑ None of these
- ❑ Ear infections
- ❑ Glasses or contacts
- ❑ Hearing loss
- ❑ Ear discharge or pain
- ❑ Frequent nosebleeds
- ❑ Ringing in your ears
- ❑ Sinus infections
- ❑ Swollen glands
- ❑ Other eye problems

Cardiovascular:

- ❑ Angina
- ❑ Leg cramps
- ❑ Swelling
- ❑ Awakening at night short of breath
- ❑ Cardiac catheterization
- ❑ Cold hands or feet
- ❑ Congenital heart defects
- ❑ Dizziness when standing up quickly
- ❑ Heart attacks
- ❑ Heart failure
- ❑ High or low blood pressure
- ❑ Irregular heart beat
- ❑ Purple fingers or lips
- ❑ Leg pain that resolves with rest
- ❑ Heart palpitations
- ❑ Varicose veins
- ❑ Chest pains
- ❑ Murmurs
- ❑ None of these

Respiratory:

- ❑ Asthma
- ❑ Breathlessness when lying flat
- ❑ Prolonged cough
- ❑ Coughing up blood
- ❑ Emphysema
- ❑ Shortness of breath
- ❑ Tuberculosis
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Wheezing
- ❑ Pleurisy
- ❑ None of these

Skin:

- ❑ Abscess
- ❑ Dandruff
- ❑ Acne
- ❑ Oily skin
- ❑ Boils
- ❑ Rashes
- ❑ Hives
- ❑ Dry skin
- ❑ Lumps
- ❑ Psoriasis
- ❑ Jaundice
- ❑ Athlete's foot
- ❑ Excessive body odor
- ❑ Excessive sweating
- ❑ Fungal infections
- ❑ Nail problems
- ❑ Moles Dash irregular
- ❑ Moles - changing / new
- ❑ None of these

Kidneys and urinary tract:

- ❑ Blood in urine
- ❑ Brown urine
- ❑ Dribbling after urination
- ❑ Painful urination
- ❑ Excessive thirst
- ❑ Frequent urination during the day
- ❑ Involuntary urination / incontinence
- ❑ Frequent urination at night
- ❑ Urine hesitancy
- ❑ Weak flow
- ❑ Frequent bladder infections
- ❑ Kidney infections
- ❑ Kidney stones
- ❑ None of these

Endocrine:

- ❑ Diabetes
- ❑ Sickle cell
- ❑ Abnormal body hair
- ❑ Changes in skin texture
- ❑ Cold intolerance
- ❑ Heat intolerance
- ❑ History of "borderline" diabetes
- ❑ None of these

Musculoskeletal:

- ❑ Anemia
- ❑ Arthritis
- ❑ Low back pain
- ❑ Gout
- ❑ Bursitis
- ❑ Joint pain
- ❑ Neck pain
- ❑ Tendonitis
- ❑ Abnormal blood count
- ❑ Blood clots in legs / lungs
- ❑ Easy bleeding
- ❑ Easy bruising
- ❑ Joint swelling
- ❑ Morning stiffness
- ❑ Muscle aches
- ❑ None of these

Gastrointestinal:

- ❑ Diarrhea
- ❑ Reflux
- ❑ Ulcers
- ❑ Hepatitis
- ❑ Abdominal pain
- ❑ Anal fissures
- ❑ Black tarry stool
- ❑ Vomiting blood
- ❑ Constipation
- ❑ Nausea
- ❑ Problems swallowing
- ❑ Hiatal hernia
- ❑ Bowel obstruction
- ❑ Liver disease
- ❑ Hemorrhoids
- ❑ Red blood after bowel movements
- ❑ Gallstones
- ❑ Vomiting
- ❑ Heartburn
- ❑ Indigestion
- ❑ None of these

Male and female:

- ❑ Painful sexual intercourse
- ❑ Loss of sexual interest
- ❑ Unprotected sex with multiple partners
- ❑ Groin itching
- ❑ Sexually transmitted disease
- ❑ None of these

Female only:

- ❑ N/A
- ❑ D & C
- ❑ Hot flashes
- ❑ Hernia
- ❑ Fibroids
- ❑ Abnormal bleeding between Cycles
- ❑ Abnormal pap smear
- ❑ Bleeding after intercourse
- ❑ Problems with pregnancy
- ❑ PMS
- ❑ Endometriosis
- ❑ Heavy bleeding during cycles
- ❑ Discharge from breasts
- ❑ Pelvic inflammatory disease
- ❑ Ovarian cyst
- ❑ Postmenopausal symptoms
- ❑ Vaginal discharge
- ❑ Vaginal dryness
- ❑ Vaginal warts
- ❑ None of these

Male only:

- ❑ N/A
- ❑ Hernia
- ❑ Sterility
- ❑ Blood in ejaculations
- ❑ Inability to complete intercourse
- ❑ Lump on testicle
- ❑ Penile discharge
- ❑ Difficulty getting or keeping erection
- ❑ Sores or warts on penis
- ❑ Prostate problems
- ❑ Testicular pain
- ❑ Testicular swelling
- ❑ None of these

Please list any condition not listed in this section

_____

_____

_____

*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 _____