Nutritional Health History

Whom may we thank for the referral _____

NAME: _____ DATE: _____
EMAIL: _____
DATE OF BIRTH: _____ WEIGHT: _____ HEIGHT: _____
Reason for consultation and/or goals: _____

_____

_____

Do you smoke? _____ How much? When? _____
Drink alcohol? _____ How much? When? _____
Do you drink caffeine every morning? _____
Do you have food allergies, restrictions, or sensitivities? Explain _____

_____
Describe your daily energy levels: _____
Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while? Explain _____

_____
Do you have Gastric reflux_____ gas_____ bloating or flatulence after meals? _____Explain more: _____

_____
How many bowel movements do you have a day? Explain _____
Rank your skin without lotion: ❒ Very Dry ❒ Dry ❒ Normal ❒ Oily ❒ Combination
Do you crave any of the following?

❒ Alcohol	❒ Bread	❒ Chocolate	❒ Desserts
❒ Fish	❒ Fried Foods	❒ Meat Fat	❒ Milk Fat
❒ Sugar	❒ Other: _____		

Do you take any nutritional supplements or vitamins?___ If so, which ones? (Be specific. Attach sheets if necessary.)

_____

_____

Which prescription and over the counter medications to you take regularly? _____

_____

_____

Which oils do you use/consume?

❒ Butter	❒ Canola	❒ Coconut Oil	❒ Corn Oil
❒ Crisco	❒ Flaxseed Oil	❒ Margarine	❒ Mayonnaise
❒ Olive Oil	❒ Peanut Oil	❒ Soybean Oil	❒ Sun/Safflower
❒ Vegetable Oil	❒ Other: _____		

Please check any of the following that pertain to you (past or present – please mark present conditions with a P)

❒ Acne	❒ Difficulty losing weight	❒ Kidney stones
❒ Addiction (Alcohol, drugs)	❒ Difficulty gaining weight	❒ Liver problems
❒ Anemia	❒ Emotional problems (instability, sensitivity)	❒ Loose stools
❒ Anorexia	❒ Emphysema	❒ Memory loss or confusion
❒ Anxiety or nervousness	❒ Fainting	❒ Nails, poor growth
❒ Arthritis (Rheumatoid or Osteo)	❒ Gall bladder problems	❒ Panic attacks
❒ Bladder infections (Cystitis)	❒ Gout	❒ Parasites
❒ Bloating, gas, or indigestion	❒ Hair loss/Poor hair growth	❒ Pregnant or nursing mother
❒ Blood sugar problems	❒ Headaches	❒ Respiratory problems
❒ Bronchitis	❒ Heart disease or problems	❒ Ringing in ears
❒ Cancer	❒ Heartburn	❒ Seizures
❒ Colds or Flu (frequent)	❒ Hemorrhoids	❒ Severe mood swings
❒ Cold sores	❒ Herpes simplex or type II	❒ Skin conditions
❒ Chronic fatigue	❒ High blood pressure	❒ Stroke
❒ Constipation	❒ High cholesterol	❒ Yeast infections
❒ Dandruff	❒ Thyroid condition	
❒ Depression	❒ Hot flashes	

Women: Please check all that pertain:

❒ PMS
❒ Irregular periods
❒ Painful periods
❒ Loss of periods
❒ Birth control pills
❒ Menopause
❒ Painful intercourse
❒ Children
❒ Hysterectomy

Men: Please check all that pertain

❒ Frequent urination
❒ Difficulty urinating
❒ Difficulty with erection
❒ Loss of libido
❒ Prostate enlargement

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

_____

_____

_____

Explain briefly your weight loss history if it pertains to your current issues: _____

_____

How is your dental health?_____

Have you ever had silver dental fillings?_____How many?_____Have they been removed?_____

Do you exercise?_____If so, what kind/How Often?_____

Please rate the following:

Daily energy level:	❒ Excellent	❒ Good	❒ Fair	❒ Poor
Energy after exercise:	❒ Excellent	❒ Good	❒ Fair	❒ Poor
Daily stress level:	❒ Excellent	❒ Good	❒ Fair	❒ Poor

Do you have a support system of family and friends?_____

General enjoyment of life: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

How many hours do you sleep/night?_____ How long does it take you to fall asleep ?_____

Do you sleep throughout the night? If not, explain your pattern_____

Do you wake up feeling restored?_____

Please describe any other health concerns you think are important:_____

_____

_____

_____

Jeanne Peters Notes on Physical Exam:

Hair_____ Nails_____ Eyes/Lids_____

Skin condition_____ Tongue_____Zinc Test_____

Other issues identified during Exam_____

Meal Pattern: **Key Food/Nutrition Issues**

By signing below, you acknowledge that any dietary or supplemental suggestions made by Jeanne Peters RD are entirely nutritional in nature, and are not intended as the diagnosis, cure, or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that you make.

Signed:_____ Date:_____