EAT WELL AGE WELL NUTRITION

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Age: _____
Address_____Telephone: _____ E-mail_____
What is the best way to get in touch with you? Text or e-mail

Occupation/Employer/School:_____

Physician' Name:_____Phone: _____

What other health professions are you working with?_____

How did you hear about us? Referral/flyer/website/other (circle)

HEALTH CONCERNS (List in order of importance and how long you have had them.)

1. _____
2. _____
3. _____

What do you believe is the cause of condition #1?
_____

If you were treated (self or doctor), what method or medicine? And what were the results?
_____

GOALS: What do you hope to get from working with a nutrition therapist? (Circle those that apply.)

- increased energy, improved appearance, feel/look younger, improved muscle tone or mass, weight loss or weight gain
- decreased stress, better sleep, improved self-esteem, decreased depression/help with moods
- to become more skilled in the kitchen preparing nutritious meals, cooking for specific condition, meal ideas and recipes, how to shop on a budget
- Digestive support, detox protocols
- Getting off of sugar, gluten and/or alcohol
- Aging and brain health, Hormone health
- Inflammation, heart health, skin health

_____

Please state your **primary goal or health condition** that you would like to address today.

Would you like to set up additional sessions to discuss other issues?_____

Level of motivation regarding your healing? very high/high/average/low/very low

What is your preferred coaching style?
No non-sense/factual, supportive and nurturing, or combination of both
Do you have a good support system in place to help you make changes in your life?_____

Would you like weekly check ins by phone, by e-mails or both?_____

PAST MEDICAL HISTORY

MEDICATIONS List all pharmaceutical medication(s) and dosage(s)that you are currently taking. Are you allergic to any medications? **Y N** *If yes,* please list:
_____

1. _____
2. _____
3. _____
4. _____

Do you have any other allergies to foods, drugs or other allergens in your environment (e.g. cats, mold, dust)?_____

Do you use non-toxic home products as well as cosmetics/ soaps etc…?_____

Have you had any amalgams taken out?_____Do you floss? Do your gums bleed?

Family member's history in terms of disease or illness that is relevant (Alzheimer's, Cancer, Depression, Heart Issues, Osteopenia/Osteoporosis, Autoimmune disease, etc.….
_____

SUPPLEMENTS *List all homeopathic remedies, herbs, vitamins and minerals with dosage that you are currently taking and why you are taking them if you know.*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

(Multi-vitamin and mineral, Vitamin D, fish oil, Vitamin K, probiotic, antioxidants, bone support, adrenal support, digestive support, mood support, memory support, etc.…)

Would you like a follow up visit to go over all your supplements?

GENERAL REVIEW

ENERGY- Best energy level? (Time of day) .....Lowest energy level? (Time of day) ....., Trouble concentrating_____, trouble remembering names _____

_____

SLEEP- Sleep well? Wake feeling rested? Trouble going to sleep? Trouble staying asleep? Sleep Apnea, soreness in joints upon rising,_____
_____Are you a morning, afternoon or night person?

SEXUAL CONCERNS- low libido, painful intercourse, vaginal dryness_____

PERIMENOPAUSAL/MENOPAUSAL ISSUES: hot-flashes, night sweats, irritable, weepy, dry skin and hair_____Taking Hormones?_____List types

MENSTRUAL ISSUES irregular periods, heavy bleeding_____

Are you taking birth control? _____What kind?_____

STRESS LEVEL on a scale of 1-10 (10 being the highest)_____

Stress relieving methods (yoga, Pilates, reading, music, nature, gardening, church etc.…)

_____Do you walk without shoes on the grass or earth from time to time

EXERCISE (What kind, how often, weight training, sprinting)_____
_____(hiking, walking, swimming, tennis, aerobics class, paddle boarding, skiing, snowboarding, etc.…)

Overexercising? _____

Muscle soreness and recovery time_____

Injuires_____

Weight_____

Balance issues_____

Do you feel your temperature runs warm or cool?

DIGESTION: gas, bloating, clearing throat, food in stools, constipation, diarrhea, acid reflux, hungry for meals?

Low blood sugar/highs and lows? Do you take enzymes or HCL, Dry brushing, hydrotherapy, infrared sauna or
steams_____
_____

FOOD & DIET- Give 3 typical meals for each category.

Breakfast (time_____)

1. _____
2. _____
3. _____

Lunch (time_____)

1. _____
2. _____
3. _____

Dinner (time_____)

1. _____
2. _____
3. _____

Snacks _____

Desserts_____

Beverages Coffee –plain, with skim, 1 %, 2%, whole milk-grass-fed or not, organic or not, with cream, with creamer-what kind, with MCT oil, with ghee, Tea- sweetened? Kombucha, Kefir_____

Alcohol_____

Water _____/day Filtered? Y N Do you have a filter for your shower? _____

Additional comments to consider: (types of oils, type of milk, dairy free or not, eats legumes or not, eats grains or not, soaks grains and seeds, gluten-free, meat eater, types of proteins eaten and how much per serving, vegetarian, organic produce or not, grass-fed or conventially raised meats, vegan, types of cooking pans used, fermented foods, fish and seafood, type of salt, types of sweeteners if any, do you worry about getting too much fat?, craves salty foods, craves sweet food

_____