



NUTRITIONAL CONSULTATION INTAKE FORM

Please complete as much of this questionnaire as possible in preparation for your appointment to develop your nutrition plan. Please read and sign the “Agreement and Understanding” page at end of document before your scheduled appointment.

Name _____ Sex ____ Date ____/____/____

Birth date ____/____/____ Height _____ Weight _____

Weight:

Amount Over or Under Weight _____ Blood Pressure _____ Pulse _____

Goal weight _____

Do you wish to consult (check one)

- For a nutritional evaluation
- For a particular health concern
- For a particular food allergy

Describe:

Do you feel that you are basically healthy? _____ What are your primary concerns?

Family Health History

Member	Age if Living	State of Health	Age at Death	Cause of Death or Health Concerns
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother's	_____	_____	_____	_____
Sister's	_____	_____	_____	_____
Children	_____	_____	_____	_____

Check Disease(s) Known to Have Occurred In the Family

- | | | | |
|--|---|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Allergy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Others _____ | |

About Yourself:

Work: Present Occupations _____

Check One: Single Married Widow(ed) Divorced

Live with: Family Alone Other _____

Do you smoke tobacco? _____ Amount? _____ How Long? _____

If stopped, how long since you quit? _____

Do you drink caffeine? _____ Amount? _____ How long? _____

Do you use recreational drugs? _____ If yes, Which? _____ How often? _____

If stopped, how long since you quit? _____

Past History

Have you had, or do you have....?
 (Please check yes or no. If **yes**, indicate **when**)

Fever, chills, night sweats	Yes _____	No	Blood in stools	Yes _____	No
Severe or frequent headaches	Yes _____	No	Diarrhea	Yes _____	No
Periods of unconsciousness	Yes _____	No	Constipation	Yes _____	No
Complete or partial blindness	Yes _____	No	Alternating diarrhea	Yes _____	No
Frequent dizzy spells	Yes _____	No	and constipation	Yes _____	No
Hearing trouble	Yes _____	No	Frequent indigestion/gas	Yes _____	No
Eye trouble	Yes _____	No	Ulcer of stomach	Yes _____	No
			Burning during urination		
Do you feel anxious, Depressed or irritable	Yes _____	No	Blood in urine	Yes _____	No
Trouble dealing with stress	Yes _____	No	Urinate frequently	Yes _____	No
Hay fever or sinus trouble	Yes _____	No	Urinate during the night	Yes _____	No
Goiter or thyroid trouble	Yes _____	No	Kidney or bladder stones	Yes _____	No
Asthma	Yes _____	No	Protein/albumin in urine	Yes _____	No
Cough	Yes _____	No	Trouble starting urine stream	Yes _____	No
Mucous in chest or Bronchial area	Yes _____	No	Urinary Infection	Yes _____	No
Venereal Disease or Herpes	Yes _____	No			
Shortness of breath	Yes _____	No	Diabetes or sugar in urine	Yes _____	No
Coughed up blood	Yes _____	No	Hypoglycemia	Yes _____	No
High Blood Pressure	Yes _____	No	Arthritis, Bursitis, Rheumatism	Yes _____	No
Heart Trouble	Yes _____	No	Nervous breakdown	Yes _____	No
Have you ever had Jaundice, hepatitis, Or mono	Yes _____	No	Skin rashes	Yes _____	No
Do you awaken at Night out of breath	Yes _____	No	Is your appetite good	Yes _____	No
Fast, irregular, or slow	Yes _____	No	Do you exercise at least three times per week	Yes _____	No
Pulse	Yes _____	No	Do you sleep well	Yes _____	No
Pain in Chest in the morning	Yes _____	No	Do you feel rested in	Yes _____	No
Do you feel tired after Eating	Yes _____	No	Allergies	Yes _____	No
Frequent Colds or flu	Yes _____	No	Varicose veins	Yes _____	No
			Tired or diminished energy during the day	Yes _____	No
Vomit Blood	Yes _____	No	Swollen lymph glands	Yes _____	No
Recent change in Bowel habit	Yes _____	No	Black bowel movements	Yes _____	No

Serious illness as a child: (check the appropriate one(s))

Rheumatic Fever Kidney Trouble Prolonged Fever
 Heart Trouble Other _____

Serious Illnesses as an adult: _____

Allergies: _____

Current Medications: _____

Past Medications: _____

Operations/Injuries:

_____ When? _____

_____ When? _____

Have you ever been in the hospital for other reasons? (Please indicate when and why)

Has your weight changed in the past year? Yes No

If yes, how much? _____ Current weight _____

Weight 1 year ago (approx) _____ Weight 5 years ago _____

For Women

Age when menstrual periods began: _____ Ended: _____

How frequent are periods: _____ How long: _____

Excessive flow? Yes No Spotting between periods Yes No

Pain/cramps during periods? Yes No

Blood clots during periods? Yes No If yes, color _____

Sharp pain in ovaries? Yes No If yes, what side _____

Lumps in _____ Breast _____ Armpit _____ Groin area

Hysterectomy? _____ Yes No If yes, when? _____

Have you taken birth control pills? Yes No For how long? _____

If you have since stopped taking birth control pills, when did you stop? _____

For all Clients

Please use this space to write in any other important health considerations you may have. The more specific, yet descriptive, your information is, the more we will be able to help you.

If you are paying by credit card: Name on card _____

Card Number _____ Exp. Date _____

Check - Please make checks out to: **The Center for Mind and Body Wellness**

Thank you very much for your cooperation. We wish you abundant well-being and happiness!

NUTRITIONAL CONSULTATION AGREEMENT AND UNDERSTANDING

Prior to receiving your nutritional consultation at the Center for Mind and Body Wellness please sign below that you have read and understand the following:

I understand that the Nutritional Consultant at the Center for Mind and Body Wellness is not providing medical services. I will not consider anything she says to substitute in any way for consultation, diagnosis, and treatment by a licensed primary health care provider, such as an M.D. Our nutritional consultants are not licensed medical doctors (M.D.) or licensed primary health care providers. Therefore, they do not diagnose, prescribe, or treat specific medical symptoms, injury or disease. This appointment is for educational purposes only. If I want medical advice or treatment, The Center for Mind and Body Wellness recommends that I consult with a licensed primary health care provider. I understand that I am receiving nutritional counseling from a Clinical Nutritionist and Nutritional Counselor who conveys self-help information that I can use to increase my own healthy and well-being. I affirm my right to self-health and I take full responsibility for my healing process.

Signature: _____ Date: _____

Address: _____

Telephone: (home) _____ (work) _____

Following completion of this Nutritional Consultation Intake Form, **please FAX to: The Center for Mind and Body Wellness at 858-566-6526** or mail to: **9466 Black Mountain Rd. #130, San Diego, CA. 92126 Attention: Nutritional Consultant**

We look forward to meeting with you.