

Advanced Nutritional Solutions Intake and Assessment

Name _____ Age _____ DOB _____ Date _____

Address _____ City, _____ State _____ Zip Code _____

Home Phone _____ Work _____ Cell _____

Fax Number _____ E-mail Address _____

Marital Status: Single, Married, Divorced, Widow/Widower, Spouse's Name _____

Child(s) & Ages _____ Your Height _____ Weight _____

Hours of Exercise per week? _____ Water type and Intake per day (e.g. well or city) _____

Surgeries? _____

Blood Pressure: High? _____ Low? _____ Normal _____ Other Heart Conditions? _____

Alcohol intake per week _____ Tobacco or recreational drugs _____ Soda/diet Pop & diet food _____

Prescription drugs _____

Nutritional products/Vitamins _____

Sleeping patterns _____ Food Cravings _____ Caffeine intake _____

How do you handle stress? _____ How many filling/root canals do you have? _____

Health Goals? _____

Childhood Illnesses, _____ Mono? _____ Acne? _____

History of family illness, i.e., cancer, diabetes, high blood pressure? _____

Mother living? yes ___ no ___ Age & cause of death _____

Father living? yes ___ no ___ Age & cause of death _____

Bowel movements: _____ per day _____ week? _____ Constipation? _____ Diarrhea? _____

Blood type _____ Reactions to spider or insect bite? _____ Known food allergies? _____

Current complaint, illness or symptoms _____

Typical Breakfast? _____ Lunch? _____ Dinner? _____

Snacks? _____

Artificial Sweeteners _____ Notes _____

WOMEN ONLY:

At what age did you begin menstruation? _____ Describe menstrual cycle _____

When was your last period? _____ Have you ever used HRT? _____ Birth Control Pills? _____

Visa or MC number _____ Exp date _____

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

- | | |
|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Difficulty losing weight | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Addiction (alcohol, drugs) | <input type="checkbox"/> Colds or flu (frequent) |
| <input type="checkbox"/> Difficulty gaining weight | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Severe mood swings |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Emotional problems (instability or sensitivity) | <input type="checkbox"/> Herpes simplex or type II |
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Memory loss or confusion | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Nails, poor growth | <input type="checkbox"/> Suicidal tendencies |
| <input type="checkbox"/> Arthritis (Rheumatoid or Osteo) | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Bladder infections (Cystitis) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Parasites | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Bloating, gas or indigestion | <input type="checkbox"/> Diabetes I (insulin dependent) |
| <input type="checkbox"/> Hair loss or poor hair growth | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Pregnant or nursing mother | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Blood Sugar problems | <input type="checkbox"/> Diabetes II (adult onset) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Multiple chemical sensitivity |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Heart disease or problems | <input type="checkbox"/> Intestinal problems |
| <input type="checkbox"/> Ringing in ears | |

Women: Please check all that pertain:

- PMS
- Frequent urination
- Irregular periods
- Painful periods
- Loss of periods
- Loss of libido
- Birth control pills
- Menopause
- Painful intercourse
- Children
- Hysterectomy

Men: Please check all that pertain:

- Frequent urination
- Difficulty with erection
- Loss of libido
- Prostate enlargement

For Office Use Only (Place an "X"):

- | | | |
|--------------------------|--------------------------|-------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Corn |
| <input type="checkbox"/> | <input type="checkbox"/> | Eggs |
| <input type="checkbox"/> | <input type="checkbox"/> | Milk |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheat |
| <input type="checkbox"/> | <input type="checkbox"/> | Soy |
| <input type="checkbox"/> | <input type="checkbox"/> | Sugar |

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

Please rate the following:

Daily energy level: Excellent Good Fair Poor

Energy level after exercise: Excellent Good Fair Poor

Daily stress level: Very High High Moderate Low None

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

General enjoyment of life: Excellent Good Fair Poor

How many hours do you sleep? ___ Do you sleep throughout the night? ___ Do you wake up without an alarm? _____

Do you wake up feeling rested? _____ Do you fall asleep within 15 minutes? _____

Please describe any health concerns you think are important:

Please mail or fax the completed form to the address above.