



**PATIENT PROFILE**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Nickname: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_

**A note to my patients:** This is a confidential record of your medical treatment and will not be released, except when you have provided me with written authorization to do so. Thank you.

What goals do you have for your visit? \_\_\_\_\_

Have you ever consulted a Nutritionist or a Counselor before? yes, no (please circle)

**PRESENT HEALTH CONCERNS**

| Please list most important health concerns in their order of significance. | Prior diagnosis of this problem? If so, what? | Indicate past and/ or present treatment |
|--|---|---|
| 1.   |   |   |
| 2.   |   |   |
| 3.   |   |   |
| 4.   |   |   |

Please list prescription medications that you are currently taking, with dosages:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Have you ever been diagnosed with a food allergy or sensitivity? If so, please explain. If no, do you suspect that you have one?

\_\_\_\_\_  
\_\_\_\_\_

Please list any severe or life-threatening allergies: \_\_\_\_\_

Explain: \_\_\_\_\_

What is your current body weight? \_\_\_\_\_ Do you have a weight goal in mind? \_\_\_\_\_

If yes, when is the last time you were at this weight and how long were you able to maintain this? \_\_\_\_\_

**Personal Habits**

Please circle any of the following substances that you use regularly: Tobacco - Coffee/ tea/cola – Alcohol - Recreational Drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: \_\_\_\_\_

Do you exercise regularly? Yes No What type? \_\_\_\_\_

How long? \_\_\_\_\_ How often? \_\_\_\_\_ How many hours a night do you sleep? \_\_\_\_\_

**Past History:**

Hospitalizations: \_\_\_\_\_

Date of last antibiotic round? \_\_\_\_\_ Is there a history of taking antibiotics? \_\_\_\_\_

Serious Illnesses and Injuries: \_\_\_\_\_

Date of last physical/annual exam \_\_\_\_\_ Date of last blood tests: \_\_\_\_\_

**Symptoms:**

Please circle all that relate to you.

|                          |   |   |                             |   |
|--------------------------|---|---|-----------------------------|---|
| Irritable bowel syndrome | gas, belching, fatigue after meals                        | Cough (unproductive)                                | Mood swings                 | Tinnitus (with normal hearing and other causes ruled out) |
| Skin rashes              | Spastic Colon   | Mental Dullness                                     | Hoarseness                  | Sinus or migraine headaches                               |
| Vertigo                  | Post nasal drip   | Muscle spasms, soreness or weakness                 | Asthma or asthma bronchitis | Chronic fatigue   |
| Itchy eyelids            | Fluctuating hearing loss (feels like ears are stopped up) | Forgetfulness                                       | Chronic fatigue             | Weight fluctuations/ intermittent swelling or edema       |
| Sleep apnea or insomnia  | Cardiac rhythm disturbances                               | Depression aggravated or worsened by food allergies | Bloating                    | Intermittent diarrhea, and constipation                   |

**Social History:**

Please circle those that apply: Single Married Significant other

Do you have any children? Yes No Please list their age(s) \_\_\_\_\_

Please bring this completed intake form with you to your first appointment. Thank You!