Healthy Nest nutrition

Client Intake Form

Please fill out this form as best as you can. If there are questions you don't understand, or don't want to fill out, we can discuss them during our first meeting. Thank You.

General Information

Name _____ Date_____

Telephone (H) _____ (C) _____

Email address _____ Referred By: _____

Mailing address _____

Personal Information

Gender_____Age _____Height_____Weight_____Marital Status_____

Children_____Stress Level (on scale 0-10)_____Regular hours in work week _____

List your stressors_____Occupation_____

How do you sleep?_____Bedtime_____Waking time(s)_____

List all regular exercise (include frequency & duration)_____

Are you currently seeing another therapist at this time? Y N for what reason?_____

Do you smoke?	Y	N	How much?_____
Do you drink alcohol?	Y	N	How many per week?_____
Do you use recreational drugs?	Y	N	How often?_____

Health History

How would you describe your health in general? _____

_____

What are your health goals? Please list and order based on priority to you?_____

_____

What is your chief complaint? _____

_____

Severity of symptoms: ❑ Mild (tolerable) ❑ Moderate (bothersome) ❑ Severe (Interferes with my life)

Dental work done within the past 2 years_____

When was the last time you were on a course of antibiotics? _____
What were the antibiotics prescribed for?_____

How often do you have bowel movements?_____

Do you have any known allergens Y N If yes, list allergy and symptoms_____

Do you know your blood type? Circle: A B AB O

Family History

Do you or anybody in your family have the following conditions? Use "self," "mother," "father," "sibling," "other" to answer.

Alcoholism_____
Allergies_____
Arthritis_____
Autoimmune problems_____
Bone/skeletal problems_____
Brain/neurological problems_____
Cancer_____
Diabetes_____
Digestive/crohns/colitis_____
Eye/vision problems_____
Genital/reproductive problems_____
Heart Disease_____
High blood pressure_____
Intestinal problems_____
Kidney/bladder problems_____
Liver problems_____
Respiratory problems_____
Skin/eczema issues_____
Thyroid problems_____

Women Only

Please circle all that apply

Premenopausal (perimenopausal)
Regular periods (regular intervals)
Irregular periods (long or short)
Post-menopausal
Pregnant now
Trying to get pregnant
Currently taking the pill
Taken pill more than 12 months
Taking hormone replacement

Do you have PMS symptoms? Please describe_____

Eating Habits

Do you drink coffee? Y N How much per day? _____
Do you drink sodas? Y N How much per day? _____
Do you drink water? Y N How much per day? _____

List your favorite foods _____

List foods that you absolutely will not eat _____

Describe an average breakfast (Please be realistic) _____

Describe an average lunch _____

Describe an average dinner _____

Do you eat snacks during the day Y N If yes, at what times?_____

How often to you eat fish?_____How often to you eat nuts? _____
List 3 worst foods you eat during an average week_____
List 3 healthiest foods you eat during an average week_____

What is your present diet? (vegetarian, gluten-restricted, vegan, dairy-restricted, kosher, other?
_____

Is your present diet working for you?_____

Eating Patterns*: check all that apply*

- ❑ emotional eater
- ❑ forget to eat
- ❑ hungry all of the time
- ❑ eat out of boredom
- ❑ late night snacker
- ❑ fast eater
- ❑ make healthy choices
- ❑ make poor choices
- ❑ eat in car/at computer

I eat:
❑ too much ❑ just enough ❑ too little

Who generally prepares the meals in your home?_____
How many times a day do you eat on average? _____
How many times per week do you eat out of the home (at a restaurant/in car/at work)? _____

Current Medications: List any medications, vitamin & mineral supplements you regularly take. Use back too.

Medications/Supplements	Reason Taking	Is it helping?

Metabolic Assessment

Please circle the appropriate number 0-3 on all questions below. 0=least/never, 3=the most/always

Part I						**Part VI continued**					
Feeling that bowels do not empty completely	0	1	2	3		Excessive passage of gas	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3		Nausea &/or vomiting	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3		Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2	3
Diarrhea	0	1	2	3		Frequent urination	0	1	2	3
Constipation	0	1	2	3		Increased thirst and appetite	0	1	2	3
Hard dry small stool	0	1	2	3		Difficulty losing weight	0	1	2	3
Coated tongue, fuzzy debris on tongue	0	1	2	3		**Part VII**				
Pass large amounts of foul smelling gas	0	1	2	3		Greasy or high –fat foods cause distress	0	1	2	3
More than three bowel movements daily	0	1	2	3		Lower bowel gas or bloating several hours after eating	0	1	2	3
Use laxatives frequently	0	1	2	3		Bitter metallic taste in mouth especially in the morning	0	1	2	3
Part II						Unexplained itchy skinny	0	1	2	3
Increasing frequency of food reactions	0	1	2	3		Yellowish cast to eyes	0	1	2	3
Unpredictable food reactions	0	1	2	3		Stool color alternates from clay colored to dark brown	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3		Reddened skin, especially palms	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3		Dry or flaky skin or hair	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3		History of gallbladder attacks or stones	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3		Have you had your gallbladder removed		yes	no	
Part III						**Part VIII**				
Intolerance to smells	0	1	2	3		Acne and unhealthy skin	0	1	2	3
Intolerance to jewelry	0	1	2	3		Excessive hair loss	0	1	2	3
Intolerance to shampoos, lotion, detergents, etc.	0	1	2	3		Overall sense of bloating	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3		Bodily swelling for no reason	0	1	2	3
Constant skin outbreaks	0	1	2	3		Weight gain	0	1	2	3
Part IV						Poor bowel function	0	1	2	3
Excessive belching, burping or bloating	0	1	2	3		Excessively foul-smelling sweat	0	1	2	3
Gas immediately following a meal	0	1	2	3		**Part IX**				
Offensive breath	0	1	2	3		Crave sweets during the day	0	1	2	3
Difficult bowel movements	0	1	2	3		Irritable if meals are missed	0	1	2	3
Sense of fullness during or after meals	0	1	2	3		Depend on coffee to keep yourself going or started	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3		Get lightheaded if meals are missed	0	1	2	3
Part V						Eating relieves fatigue	0	1	2	3
Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3		Feel shaky, jittery, or have tremors	0	1	2	3
Use antacids	0	1	2	3		Agitated, easily upset, nervous	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3		Poor memory/forgetful	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3		Blurred vision	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3		**Part X**				
Digestive problems subside with rest & relaxation	0	1	2	3		Fatigue after meals	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol & caffeine	0	1	2	3		Crave sweets during the day	0	1	2	3
Part VI						Sweets don't relieve sugar cravings	0	1	2	3
Roughage and fiber cause constipation	0	1	2	3		Must have sweets after meals	0	1	2	3
Indigestion & fullness lasts 2-4 hours after eating	0	1	2	3		Waist is equal or larger than hip girth	0	1	2	3
Pain & soreness on the left side under rib cage	0	1	2	3		Frequent urination	0	1	2	3

Part X continued						**Part XV**				
Increased thirst and appetite	0	1	2	3		Heart palpitations	0	1	2	3
Difficulty losing weight	0	1	2	3		Inward trembling	0	1	2	3
Part XI						Increased pulse even at rest	0	1	2	3
Cannot stay asleep	0	1	2	3		Nervous and emotional	0	1	2	3
Crave salt	0	1	2	3		Insomnia	0	1	2	3
Slow starter in the morning	0	1	2	3		**Part XVI**				
Afternoon fatigue	0	1	2	3		Diminished sex drive	0	1	2	3
Dizziness when standing up quickly	0	1	2	3		Menstrual disorders or lack of menstruation	0	1	2	3
Weak nails	0	1	2	3		Increased ability to eat sugars Without symptoms	0	1	2	3
Part XII						**Part XVII**				
Cannot fall asleep	0	1	2	3		Increased sex drive	0	1	2	3
Perspire easily	0	1	2	3		Tolerance to sugars reduced	0	1	2	3
Under high amounts of stress	0	1	2	3		“Splitting” type headaches	0	1	2	3
Weight gain when under stress	0	1	2	3		**Part XVIII (MALES ONLY)**				
Wake up tired even after 6 or more hours of sleep	0	1	2	3		Urination difficulty or dribbling	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3		Frequent urination	0	1	2	3
Part XIII						Pain inside of legs or heels	0	1	2	3
Edema and swelling in ankles and wrists	0	1	2	3		Feeling incomplete bowel emptying	0	1	2	3
Muscle cramping	0	1	2	3		Leg twitching at night	0	1	2	3
Poor muscle endurance	0	1	2	3		**Part XIX (MALES ONLY)**				
Frequent urination	0	1	2	3		Decreased libido	0	1	2	3
Frequent thirst	0	1	2	3		Decreased number of spontaneous morning erections	0	1	2	3
Crave salt	0	1	2	3		Decreased fullness of erections	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3		Difficulty maintaining morning Erections	0	1	2	3
Alteration in bowel regularity	0	1	2	3		Spells of mental fatigue	0	1	2	3
Inability to hold breath for long periods	0	1	2	3		Inability to concentrate	0	1	2	3
Shallow, rapid breathing	0	1	2	3		Episodes of depression	0	1	2	3
Part XIV						Muscle soreness	0	1	2	3
Tired/sluggish	0	1	2	3		Decrease in physical stamina	0	1	2	3
Feel cold-hands, feet, all over	0	1	2	3		Unexplained weight gain	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3		Increase in fat distribution around chest and hips	0	1	2	3
Increase in weight even with low calorie diet	0	1	2	3		Sweating attacks	0	1	2	3
Gain weight easily	0	1	2	3		More emotional than in the past	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3		**Part XX (MENSTRUATING FEMALES ONLY)**				
Depression/lack of motivation	0	1	2	3		Perimenopausal	0	1	2	3
Morning headaches that wear off ask the day progresses	0	1	2	3		Alternating menstrual cycle lengths	0	1	2	3
Outer third of eyebrow thins Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3		Extended menstrual cycle (greater than 32 days)	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3		Shortened menses, less than every 24 days	0	1	2	3
Mental sluggishness	0	1	2	3		Pain and cramping during periods	0	1	2	3

Part XX **menstruating females continued**										
Scanty blood flow	0	1	2	3						
Heavy blood flow	0	1	2	3						
Breast pain and swelling during menses	0	1	2	3						
Pelvic pain during menses	Yes	No								
Irritable and depressed during menses	Yes	No								
Acne breakouts	Yes	No								
Facial hair growth	Yes	No								
Hair loss/thinning	0	1	2	3						
Part XXI **(MENOPAUSAL FEMALES ONLY)**										
How many years have you been Menopausal?	____	years								
Since menopause, do you ever have uterine bleeding?	Yes	No								
Hot flashes	0	1	2	3						
Mental fogginess	0	1	2	3						
Disinterest in sex	0	1	2	3						
Mood swings	0	1	2	3						
Depression	0	1	2	3						
Painful intercourse	0	1	2	3						
Shrinking breasts	Yes	No		3						
Facial hair growth	0	1	2	3						
Acne	0	1	2	3						
Increased vaginal pain, dryness or itching	0	1	2	3						

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

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