Your health and well-being are influenced by many different things, including lifestyle, family history, emotional health, physical activity and nutrition/eating habits. Please complete the following assessment to the best of your ability to provide us an overall view of your general lifestyle and health.

ALLISONVILLE
INTEGRATIVE HEALTH

NEW PATIENT NUTRITION ASSESSMENT

First Name _____ M.I. _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Birth Date _____/_____/_____ Age _____

Home # _____ E-Mail _____

Marital Status: Married / Single / Divorced Occupation _____

Do you have children? Yes / No Names & Ages of Children _____

Are you pregnant? Yes / No _____

Due Date: _____/____/_____ _____

With whom do you live? (Include children, parents, relatives and / or friends and ages of each)

_____

_____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone: _____

Primary Care Provider _____ Phone _____

Other doctors / practitioners you see _____

_____

GOALS and READINESS ASSESSMENT

I would like to visit with the nutrition counselor today because....

_____

_____

My overall health and wellness goals are:

- □ Create a healthy lifestyle
- □ Learn to balance activity and diet
- □ Advice on disease prevention
- □ Reduce stress
- □ Weight management
- □ Decrease body fat
- □ Supplementation advice based on my specific needs
- □ Improve digestion
- □ Feel better
- □ Other _____
- □ Improve overall health
- □ Advice on healthy habits / regimen
- □ Learn how to reduce or eliminate medications
- □ Increase energy / activity level
- □ Anti-aging strategies
- □ Improve athletic performance
- □ Improve balance / coordination
- □ Improve flexibility
- □ Reduce or eliminate muscle or joint discomfort

If I could change three (3) things about my health and nutritional habits, they would be....

_____

_____

_____

I am motivated by....

- □ Accountability
- □ Having fun
- □ Praise / rewards
- □ Seeing results for my efforts
- □ Feeling better
- □ Other _____

The biggest challenges to reaching my health and wellness goals is / are:

- □ Lack of motivation
- □ Lack of equipment
- □ Lack of knowledge (not knowing how or what to do)
- □ Lack of results (discouraged)
- □ Lack of energy
- □ Time
- □ Self – conscious
- □ No support
- □ Hitting a plateau
- □ Other _____

To Improve my health, I am READY / WILLING to...

- □ Significant modify my diet
- □ Keep a record of everything I eat / drink
- □ Modify my lifestyle (work demands, sleep, activity)
- □ Take nutritional supplement daily
- □ Practice relaxation techniques
- □ Engage in regular exercise / activity

PAST MEDICAL HISTORY

Please indicate what DISEASE, SYMPTOM, INJURY, SURGERY or CONDITION you or a relative have been diagnosed with and / or for which treatment has been provided.

ILLNESS / SYMPTOM / INJURY / SURGERY	Date(s)	Age when diagnosed / treated	Describe / Specify
Allergies (specify type)			
Anemia			
Anxiety			
Arthritis			
Asthma			
Autoimmune condition (specify)			
Bronchitis			
Cancer			
Chronic fatigue syndrome			
Crohn's disease or Ulcerative Colitis			
Depression			
Diabetes (specify type)			
Dry, itchy skin, rashes, dermatitis			
Eczema			
Emphysema			
Epilepsy, convulsions, seizures			
Eye disease (specify)			
Fibromyalgia			
Food allergies or sensitivities (specify)			
Fungal infection			
Gall bladder disease/gallstones (specify)			
Gout			
Heart attack / angina			
Heartburn			
Heart disease (specify)			
Hepatitis			
High blood fats (cholesterol/triglycerides)			
High blood pressure (hypertension)			
Hypoglycemia (low blood sugar)			
Intestinal Disease			
Inflammatory Bowel Disease (specify)			
Irritable bowel syndrome			
Kidney disease			
Lung disease			
Liver disease			
Mononucleosis			
Osteoporosis			

ILLNESS / SYMPTOM / INJURY / SURGERY	Date(s)	Age when diagnosed / treated	Describe / Specify
PMS			
Polycystic Ovarian Syndrome			
Pneumonia			
Prostrate problems (specify)			
Psychiatric conditions (specify)			
Sinusitis			
Sleep apnea			
Stroke			
Thyroid disease			
Urinary tract infection			
Injury (specify)			
Operations (specify)			
Other (specify)			

List any medical symptoms you have experienced in the last 6 months in the following areas:

□ Head _____ □ Eyes _____

□ Ears _____ □ Nose _____

□ Mouth/throat _____ □ Skin _____

□ Heart _____ □ Lungs _____

□ Digestive tract _____ □ Joint/muscle_____

□ Mind/mental _____ □ Emotions _____

□ Weight _____ □ Energy/Activity _____

□ Other _____ □ Other _____

To help identify any deficiencies or nutrients that may be out of "healthy" or "normal" range, would you like to meet with our nurse practitioner and have a blood panel ordered? ( ) YES ( ) NO
(in most, this is covered by insurance)

MEDICATION AND SUPPLEMENT INTAKE

Medication/Supplement	Why? For what?	Dose / Units	Frequency	Start Date	Stop Date

Do you have allergies to any medications, herbs or supplements? Yes / No

Please explain: _____

LIFESTYLE

PHYSICAL ACTIVITY

ACTIVITY	TYPE / INTENSITY (low-moderate-high)	DURATION (minutes)	# DAYS / WEEK

If you have been exercising regularly, what results or changes have you seen? _____

_____

_____

Do you have any physical limitations or is there anything that inhibits or limits your participation in an exercise program? YES / NO
Please explain _____

_____

Are you interested in learning about options regarding a physical workout program? □ **YES** □ **NO**

Indicate daily stressor and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work ____ Family _____ Social _____ Financial ____ Health ____ Other _____

On average, how many hours of sleep per night do you get? Weekdays _____ Weekends _____

Do you smoke? ( ) Never ( ) In the past ( ) Currently How long? _____

Alcohol use? ( ) Never ( ) In the past ( ) Currently -Type/amount/frequency _____

Drug use? ( ) Never ( ) In the past ( ) Currently – Type/Frequency _____

WEIGHT HISTORY

Would you like to be weighed and have measurements taken today? ( ) Yes ( ) No

Height: _____ Current Weight _____ Desired Body Weight _____

When were you last at your desired body weight? Age _____ Date: _____ (mo / year)

Have you had recent changes in your weight (within the last 0-6 months) that you are concerned about?
( ) YES ( ) NO If YES, please explain _____

_____

DIGESTIVE HISTORY

- Do you associate any digestive symptoms with eating certain foods? ( ) Yes ( ) No

  Please explain _____

  _____

- Do you associate any digestive symptoms with any other habits? ( ) Yes ( ) No

  Please explain _____

  _____

- Do you associate any digestive symptoms with the environment / stress? ( ) Yes ( ) No

  Please explain _____

  _____

- How often do you have a bowel movement? _____
  Type (hard / loose / soft / runny) _____

- Please indicate how often you experience the following symptoms:

Heartburn	Often	Sometimes	Never
Gas	Often	Sometimes	Never
Bloating	Often	Sometimes	Never
Stomach Pain	Often	Sometimes	Never
Nausea / Vomiting	Often	Sometimes	Never
Diarrhea	Often	Sometimes	Never
Constipation	Often	Sometimes	Never

DIET HISTORY

- Do you follow a special diet / nutritional program (check if applicable)? If so, how long?

  ( ) Low Fat _____ ( ) Low Carb _____ ( ) Low Sodium _____

  ( ) No Gluten _____ ( ) No Dairy _____ ( ) High Protein _____

  ( ) Vegetarian _____ ( ) Vegan _____ ( ) Diabetic _____

  ( ) Weight Loss _____ ( ) Weight Gain _____ ( ) Other _____

- Which meals do you eat regularly? Time?

  ( ) Breakfast _____ ( ) Lunch _____ ( ) Snacks _____ ( ) Dinner _____

- What liquids do you drink? How often? When?

  ( ) Water _____ ( ) Tea _____ ( ) Coffee _____

  ( ) Juice _____ ( ) Soda _____ ( ) Milk _____

  ( ) Milk alt _____ ( ) Other _____ ( ) Other _____

- Do you eat any of the following? How often?

  ( ) Organic fruit _____ ( ) Organic vegetables _____

  ( ) Raw fruits / vegetables _____ ( ) Cooked vegetables _____

  ( ) Fried foods _____ ( ) Fast foods _____

  ( ) Convenience foods _____ ( ) Canned foods _____

  ( ) Meats _____ ( ) Fish/seafood) _____

  ( ) Dairy _____ ( ) Breads _____

  ( ) Candies/sweets _____ ( ) Other _____

- Food Cravings: _____
- Food Dislikes: _____

I agree that all the information I have provided is true and accurate to the best of my knowledge.

Client Signature _____ **Date:** _____