BEACON HILL
CHIROPRACTIC AND MASSAGE

Nutritional Consultation Process

We are excited that you want to take your nutritional habits and choices into consideration for your overall well-being.

Please read this short form, and follow the steps required to prepare for the most beneficial use of your time and gain the most value from your appointment with your chiropractor for nutritional consultation.

Step 1: Request forms in person or online and complete them.

Step 2: Think carefully about what you hope to achieve most with your consultation.

Step 3: Complete **at least 1 week** worth of nutritional diary and hand in to our office for the doctor's review **prior** to your initial nutritional consultation appointment with your chiropractor **(please see attached Diet Diary)**.

Nutrition Consultation Form

Name: _____ Gender: Male / Female
Date: _____ Date of Birth: _____
Referred By: _____

Please list your primary health nutrition concerns/reason for a nutritional consultation:

_____
_____
_____

HEALTH HISTORY

Please list any medical problems that you have been diagnosed with:

_____
_____

Please list any prescribed drugs or over-the-counter medication you are currently taking:

_____
_____

Please list any vitamins, minerals, herbal or homeopathic remedies you currently take:

_____
_____

Please list any allergies or sensitivities:

_____

Please list any habits you have using substances like cigarettes, alcohol, drugs:

_____

How often do you have a bowel movement? (circle) 0 - 1 - 2 - 3 - 4 - 5 times per day

Do you strain to have a bowel movement? Yes / No
Related to any particular food or circumstances?_____

Do you have loose bowel movements? Yes / No / Occasionally
Related to any particular food or circumstances?_____

What is you current weight?_____ Ideal weight?_____

How would you rate your present energy level (1-10, 10 being highest)?_____

Exercise:

- ☐ Sedentary (No exercise)
- ☐ Mild Exercise (ie stairs, walk 3 blocks, golf)
- ☐ Occasional Vigorous Exercise (work or recreation less than 4x/week for 30min)
- ☐ Regular Vigorous Exercise (work or recreation 4x/week for 30min)

List Activities: _____

DIETARY HABITS

How many times a day do you eat:
Main Meals_____ Times of day:_____
Snacks_____ Times of day:_____

Do you have restrictions on your diet due to preferences of others (family)? Yes / No
If yes, explain:_____

How many ½ cup servings of each do you typically eat in a day:
Fruit:_____Fresh_____Dried_____Canned
Vegetables:_____Cooked_____Raw
Whole Grains:_____Type:_____
Protein:_____Type:_____
Dairy:_____Type:_____
Other: _____

Please list examples of your typical meals:
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____

Please indicate the number of cups of the following you drink per day:

____tap water	____alcoholic drinks	____diet soft drinks
____tea	____herbal tea	____soft drinks
____milk	____coffee	____juice

Are you a: (circle) Meat Eater Vegetarian Vegan
How often do you eat meat?_____
How often do you consume dairy?_____

Do you crave any foods?_____ Do you avoid any foods? _____
Explain:_____

Do you experience any symptoms if meals are missed? Explain:_____
_____

Do you experience any symptoms after meals? Explain:_____
_____

FAMILY HISTORY

Does anyone in your family have or suffer from:

___ Heart Disease	___ Hypertension	___ Diabetes
___ Allergies	___ Arthritis	___ Osteoporosis
___ Alcoholism	___ Mental Illness	___ Intestinal Disease
___ Ulcers	___ Gall Bladder Issues	___ Kidney Problems
___ Asthma/Eczema	___ Cancer; Type: _____	
___ Other; _____		

FEMALES

Are you/could you be pregnant?_____ Are you trying for pregnancy? Yes / No

Do you experience any of the following:

☐ Heavy Periods ☐ Irregular Periods ☐ PMS

Are you pre-menopausal or menopausal? Yes / No Experiencing symptoms? Yes / No
Is yes, please specify:_____

OTHER COMMENTS

_____
_____
_____

CLIENT STATEMENT

I hereby attest to the following:

1. That I am here, on this and any subsequent visit, solely on my own behalf and not as an agent for any federal, provincial, municipal or professional agency on a mission of entrapment or investigation.
2. I fully understand that Dr. Michael Schmolke, Dr. Sherra Sanders, Dr. Mehrdad Ghaliai, are not medical doctors and I am not here for medical diagnostic or treatment procedures.
3. The services provided by Dr. Michael Schmolke, Dr. Sherra Sanders, Dr. Mehrdad Ghaliai, are at all times intended for general nutritional well-being and do not involve the diagnosing, prognosticating, treatment, or prescribing of remedies for the treatment of any disease, or any licensed or controlled act which may constitute the practice of medicine in the province of Alberta.
4. This agreement is being signed voluntarily and not under duress of any kind.

Name:_____ Date:_____

Signature:_____

Address:_____

City:_____ Province:_____ Postal Code:_____

Phone:_____

Thank-you for your cooperation.
All information contained in this form will be kept strictly confidential.

Name		Weekly Diet Diary			Date:	
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
Noon	Noon	Noon	Noon	Noon	Noon	Noon
PM	PM	PM	PM	PM	PM	PM
Comments, feelings, overview of the day, improvements to make, how is your body? (energy, digestion etc.)						

DETOXIFICATION QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past month ❒ Past week ❒ Past 48 hours

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	**TOTAL** _____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	**TOTAL** _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	**TOTAL** _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	**TOTAL** _____
MOUTH/ THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	**TOTAL** _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	**TOTAL** _____
HEART	_____	Chest pain	
	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	**TOTAL** _____
LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	**TOTAL** _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	**TOTAL** _____
JOINTS/ MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Feeling of weakness or tiredness	
	_____	Pain or aches in muscles	**TOTAL** _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Water retention	
	_____	Underweight	
	_____	Compulsive eating	**TOTAL** _____
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	**TOTAL** _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	
	_____	Poor concentration	
	_____	Poor physical coordination	**TOTAL** _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	**TOTAL** _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	**TOTAL** _____
GRAND TOTAL			**TOTAL** _____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
❒ Yes (1 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)
❒ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?
❒ Cimetidine (2 pts.)
❒ Acetaminophen (2 pts.)
❒ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
❒ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
❒ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
❒ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
❒ Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
❒ Yes (2 pts.) ❒ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
❒ Yes (1 pt.) ❒ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

10. Do you have a personal history of
❒ Environmental and/or chemical sensitivities (5 pts.)
❒ Chronic fatigue syndrome (5 pts.)
❒ Multiple chemical sensitivity (5 pts.)
❒ Fibromyalgia (3 pts.)
❒ Parkinson's type symptoms (3 pts.)
❒ Alcohol or chemical dependence (2 pts.)
❒ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
❒ Yes (1 pt.) ❒ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

GRAND TOTAL: _____

For Practitioner Use Only:

OVERALL SCORE TABULATION

Recommended protocols based on new detoxification questionnaire (MSQ and XTT)

MSQ SCORE _____ (High >50; moderate 15-49: Low <14)

XTT SCORE _____ (High >10; moderate 5-9: Low <4)

			Functional Medicine Protocol		
MSQ Score	XTT Score	Description	Medical Food	Diet	Additional Nutraceutical Support
50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical food for imbalanced detoxifiers	28-day elimination diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimination diet	Consider bifunctional, antioxidant, and chlorophyllin nutraceuticals
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance

Additional Symptom-Specific Support

Symptom	Nutraceutical Support
Water retention and/or frequent or urgent urination	Kidney support nutraceuticals
Heartburn and/or intestinal/stomach pain	Functional dyspepsia nutraceuticals
Diarrhea, constipation, and/or intestinal/stomach pain	Probiotics

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.