Nutrient Deficiency Intake Form

The information requested below will assist us in helping you reach your goals safely. Feel free to ask any questions about the information being requested. Please note that all the information provided below will be kept confidential unless permission is granted by you or required by law. Your written permission will be required to release any information.

Name: _____ Date Of Birth: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____

Email: _____ (for office use only)

Who referred you to our office? _____

Have you ever been tested for nutrient deficiencies? Y / N If yes, please describe your experience (what you did / did not like): _____

_____

Current Treatment (chiropractic, massage, naturopath etc.) _____

_____

Health Goals: List one to five health goals that you would like to attain for yourself, in order of priority. How long have these been a concern for you?

1. _____
2. _____
3. _____
4. _____
5. _____

QUESTIONS:

1. What is your age? Years: _____
2. Are you Male or Female? M / F
3. Are you pregnant or trying to get pregnant? Yes No
4. Are you vegetarian or vegan? Yes No
5. What is your ethnicity?
6. How tall are you?
7. How much do you weigh?
8. Are you a current smoker? Yes No
9. Do you drink alcohol? Yes No (Beer Wine Hard Liquor)
10. On average, do you drink 3 or more units each day? Yes No (Beer Wine Hard Liquor)
11. Do you consider yourself to be over weight? Yes No
12. Do you consider yourself to be under weight? Yes No
13. Would you like to? (circle one) Lose Weight - Maintain Weight - Gain Weight
14. Do you have an active lifestyle? (Example: 30 minutes of activity 5 times per week - housework, gardening, walking, running etc.) Yes No
15. Describe the environment where you spend most of your time (air quality, light quality, etc.). On a scale of: 0 - very unhealthy to 10 - super healthy _____
16. Are you following any special diet? _____

_____

17. Do you take supplements? Yes No (Make sure to let your healthcare practitioner know about all the supplements you take)
18. When the weather is nice, how often do you spend at least 10 minutes a day in full sun without sunscreen?
19. Do you miss out on sunlight through being house bound, avoiding the sun, always cover your skin or always wearing sun cream? Yes No

20. Do you frequently take aspirin, antacids or any other non-prescription medicines? Yes / No - Please let your healthcare practitioner know what you take.

21. When do you feel you would be ready to work on your diet/nutrition habits? (Circle One) Not an issue - Not ready to change - Willing to change soon - Willing to change in the future

22. How often do you buy food from the outer aisles of the grocery store? (i.e., fresh or frozen fruits and vegetables, fresh meat or seafood, dairy, grains, and nuts from the bulk bins)
(Circle One) All the time - Often - Sometimes - Not at all

23. How often do you buy food from the center aisles of the grocery store? (i.e., foods that come in cans, bags, or boxes, such as crackers, canned soups, cereals, and frozen dinners)
(Circle One) All the time - Often - Sometimes - Not at all

24. How often do you eat out at restaurants?
(Circle One) All the time - Often - Sometimes - Not at all

25. How often do you eat out at fast-food restaurants?
(Circle One) All the time - Often - Sometimes - Not at all

26. What do you eat when you snack?_____

_____

27. How often do you eat fresh or frozen green vegetables, such as kale, collard greens, chard, or spinach?
(Circle One) All the time - Often - Sometimes - Not at all

28. How often do you eat fresh or frozen fruits and vegetables from at least 3 different color groups (e.g., red berries, purple eggplant, orange sweet potatoes, and green broccoli) all in one day?
(Circle One) All the time - Often - Sometimes - Not at all

29. What are your favorite fruits and vegetables?_____

_____

30. How often do you eat low-fat dairy products such as yogurt or cheese, soy, or rice-milk products?

(Circle One) All the time - Often - Sometimes - Not at all

31. How often do you eat fish, such as sardines, salmon, trout, and tilapia?

(Circle One) All the time - Often - Sometimes - Not at all

32. How often do you eat red meat, such as beef, mutton, lamb, goat, and game meats (e.g., rabbit, venison, buffalo)?

(Circle One) All the time - Often - Sometimes - Not at all

33. How often do you eat other meats, such as chicken, turkey, pork, and game birds (e.g., pheasant, quail)?

(Circle One) All the time - Often - Sometimes - Not at all

34. How often do you eat processed meats, such as bacon, sausage, hot dogs, and bologna?

(Circle One) Not at all - Sometimes - Often - All the time

35. How often do you eat fried, canned, or smoked meats?

(Circle One) Not at all - Sometimes - Often - All the time

36. How much salt do you use?

(Circle One)

Do not add salt at the table

Sparingly - use on a few foods

Moderately - use on some foods

I consider myself a heavy salt user

37. How much sugar do you use?

(Circle All That Apply)

None, little or no artificial sweeteners

I use only artificial sweeteners

I occasionally use sugar or eat sweets

I consider myself a heavy sugar user

I use sugar every day (in coffee, on cereal)

I have a sweet dessert or snack daily

38. How many beverages containing caffeine do you drink in a day? (For example: coffee, tea, cocoa, and many soft drinks.)?

(Circle One)

None

1 - 2 / 8 oz. servings

3 - 5 / 8 oz. servings

6 - 10 / 8 oz. servings

11+ / 8 oz. servings

For the following questions, please answer each question in the Yes / No format.

1. Is your hair dry? _____ Is your hair brittle? _____ Is your hair dull or lifeless? _____

2. Is your hair oily? _____ Is your hair falling out? _____ Is your hair thin? _____

3. Is your hair prematurely grey? _____ Do you have cowlicks? _____ Do you have dandruff? _____

4. Does your hair grow slowly? _____ How bad would you consider your hair loss? _____

5. Do you have acne? _____ Do you get pimples or blackheads, especially on your upper back or shoulders? _____

6. Do you get hives? _____ Do you get warts? _____

7. Do you get shingles? _____

8. Do you have eczema or psoriasis? _____

9. Do you get dermatitis or other skin rashes? _____

10. Do you have rough, bumpy skin on the backs of your arms? _____

11. Do you have liver (brown) spots on your skin? _____

12. Do you have little pink spots or broken capillaries on your skin? _____

13. Do you perspire or sweat excessively? _____

14. Do you feel cold and sweaty? _____

15. Do you feel warm and flushed at normal temperatures? _____

16. Is your skin warm, moist and fine textured? _____

17. Is your skin greasy and scaly around your mouth, nose or eyes?

_____

18. Is your skin oily or crusty on your nose, around your eyes, and / or forehead?

_____

19. Do you have dry or cracked skin behind your ears? _____

20. Is your skin generally dry? _____ Is your skin rough, flaky or scaly?

_____ Is your skin itchy?_____

21. Is your complexion sallow (pale grey/green/yellow tint)? _____ Is your complexion pale? _____

22. Do you have pale skin, especially on the palms of your hands?

_____

23. Do the soles of your feet and/or palm of your hands have a yellowish tint?

_____

24. Do you have white patches on your skin (vitiligo)? _____ Do you have red or inflamed skin? _____

25. Do you bruise easily? _____ Is your skin aging rapidly? _____

26. Do you have enlarged facial pores? _____ Is your skin unusually sensitive to the sun? _____

27. Do you have puffiness or bloating in your face, or under your eyes? _____

28. Are your eyes sensitive to bright light (sunlight, glare, headlights, etc.)? _____

29. Is your eyesight getting worse? _____ Do you have poor night vision? _____

30. Do you find it difficult to adjust your eyes to the light or when entering a dark room? _____

WAIVER AND RELEASE

I, _____ (the "Undersigned"), hereby consent to treatment.

I understand that such procedures are non-invasive.

The Clinic and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of testing and dietary alterations or supplementation.

I understand the unpredictable nature of nutrient deficiencies and related symptoms and that the clinic cannot guarantee any results in the reduction of symptoms.

I agree to pay the clinic the standard fee for testing administered.
IN WITNESS THEREOF, the undersigned executed the Agreement as of
DATE:

_____ _____

Signature of Undersigned Signature of Practitioner

_____

Signature of Parent or Legal Guardian