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NOURISHING BODY, MIND AND SPIRIT

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Nutrition Intake Assessment Form

For office use only:

Name: ______________________________

Date of birth: __________ Sex: F / M Height: _____ Weight: _______

Address: ______________________________

City: __________ Province: __________ Postal Code: _______

Phone: ______________ Email: ______________

Who can we thank for this referral (Google, Website, Name, Other): __________

Please answer each of the following questions to the best of your ability:

What are your main health concerns or reasons for coming? Please list in priority:

____

____

____

If your health concerns were improved, how would that change your life? __________

____

Have you experienced any major trauma in the past 5 years? __________

____

How would you rate your current stress level? 1(low) to 10 (high) __________

What are the major causes or factors of your stress? (Rate all that apply on a scale of 1-10):

___ Financial ___ Relationships ___ Spiritual

___ Career ___ Health ___ Loneliness

___ Emotional ___ Family ___ Other: __________

How does your stress manifest itself and how do you manage it? __________

____

What do you do for exercise and how often? __________

____

How would you describe your energy level on a scale of 1(low) to 10 (high)? _______

Do you experience any lulls or highs in your energy levels throughout the day? If so, at what time of day? ______________________________

How many hours on average do you sleep daily? (Include naps) __________

For office use only:

What time do you go to sleep? ____________ Awaken? ____________

Do you have trouble falling asleep? ____________ Staying asleep? ____________

Do you awaken feeling rested? ____________ Do you snore? ____________

What is your occupation? ____________ Do you enjoy your work? ____________

How many hours each day do you work? ____________

At what times do you start and end work? ____________

Do you work shifts or are you on a regular schedule? ____________

Do you smoke currently? ____ Past? ____ For how long?________ When quit? ________

If no, does anyone in your household or workplace smoke? ____________

Do you wish to gain weight? ______ Lose weight? ________ How much? ________

By when do you wish to reach your goal weight? ____________

What is your main motivation to change your weight? ____________

____

How many hours do you spend daily, on average:

Driving ______ Watching television ______ Reading ______ On the computer ______

What are your interests and hobbies? ____________

____

Do you vacation regularly? ______ When was your last vacation? ____________

Do you actively participate in any spiritual discipline (church, religious group, meditation, etc.)?

____

____

MEDICAL HISTORY:

Please list any medications and brief reason for each: ____________

____

____

Have you taken antibiotics over the past five years? ____________

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the current amounts/dosages:

____

____

____

Please list any allergies or sensitivities: ____________

____

____

Do you have anaphylaxis (life-threatening allergy)? If so, please describe: ____________

____

Do you have any silver-mercury fillings? ____________

Have you ever been:

a) Diagnosed with an illness/disease? __________ If yes, please explain: _________________

____

b) Hospitalized? ________ If yes, for what reason ____________________________________

Have you had surgery to remove your gall bladder? _____ Tonsils? _____ Appendix? ________

How often do you have a bowel movement? ____

Do you strain to have a bowel movement? _______ Related to particular food or circumstances?

____

Do you have loose bowel movements? ________ Related to particular food or circumstances?

____

Is there undigested food in your stools? ____

Do you use recreational drugs? ________ If yes, how often and what type? ________________

____

Have you ever been treated for drug and/or alcohol dependency? _______________________

____

FAMILY HISTORY:

Please indicate any family history of the following indicating "F" for father, "M" for mother, "S" sibling, "G" for grandparent, "O" for other(s):

____ Allergies	____ Arthritis	____ Autoimmune Disease
____ Diabetes	____ Gall Bladder Issues	____ Hypertension
____ Intestinal Disease	____ Mental Illness	____ Skin conditions
____ Alcoholism	____ Asthma____	____ Ulcers
____ Drug Abuse	____ Heart Disease	____ Cancer - type: _______
____ Kidney Dysfunction	____ Osteoporosis	

Other diseases (please list) ____

Have you ever experienced fungal infections (e.g. jock itch, athlete's foot)? ________________

If yes, please describe: ____

Have you experienced a decline in sexual interest? _______ If yes, please describe: __________

____

Have you had kidney or gallstones? _________ If yes, please describe: ____________________

____

FEMALES:

Are you or could you be pregnant? ____

Have you noticed any changes in menses, for example the frequency, duration, flow, clotting, or other changes? _______ If so, please specify ____

Do you suffer from PMS symptoms? Please specify _________________________________

Use of birth control and type: ____

Are you pre-menopausal? _______ Post-menopausal? _______ Are you experiencing any menopausal symptoms? ____

For office use only:

MALES:

Have you experienced any prostate problems (e.g. frequent urination, discomfort during urination)?

If yes, please describe: ____________________

DIETARY HABITS:

Times of day you eat main meals: ____________________

Times of day you eat snacks: ____________________

Please check all that apply. I usually eat:

___ With family
___ Alone
___ On the run
___ At restaurants
___ Fast food/Take out
___ Too quickly
___ Too much
___ Too little
___ To comfort myself
___ When bored
___ When I remember
___ Late at night
___ Don't enjoy eating

Who prepares/cooks most of your meals? ____________________

Do you have any dietary restrictions or follow a special diet? ____________________

____

How many ½ cup servings of each of following do you typically eat in a day?:

- Fruit: Fresh ___ Dried ___ Canned ___
- Vegetables: Cooked ___ Raw ___
- Whole Grains: ___ Types: ____________________
- Protein: ___ Types ____________________
- Dairy Products: ___ Types ____________________
- Healthy fats/oils: ___ Types (eg: coconut, olive, avocado, nuts, seeds, flax) ____________________
- Other: ___ Specify ____________________

Provide examples of your typical meals:

Breakfast: ____________________

____

Lunch: ____________________

____

Dinner: ____________________

____

Snacks: ____________________

____

Please indicate how often you use the following (1= Rarely, 2= Regularly, 3= Often):

___ Aluminum pans
___ Microwave
___ Candy
___ Fried foods
___ Luncheon/Deli meats
___ Instant/Packaged food
___ Vegetable oils (canola, soy, sunflower, margarine)
___ Artificial sweeteners (Nutra Sweet, Aspartame, Splenda)
___ Refined foods (pastries, white bread/pasta/rice, etc.)

For office use only:

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Please indicate how many cups of the following you drink per day:

___ Tap water	___ Fresh fruit juices
___ Bottled or spring water	___ Prepared fruit juices
___ Fresh vegetable juices	___ Red wine
___ Prepared vegetable juices	___ White wine
___ Coffee	___ Beer
___ Tea	___ Other alcoholic beverages
___ Herbal tea ___	___ Milk *(1%, 2% or whole)*
___ Soft drinks *(diet)*	___ Milk *(skim)*
___ Soft drinks *(regular)*	___ Other ______________

What are your favourite foods and how often do you eat them? _________________________

____

Which food(s) do you crave, and how often do you eat them? __________________________

____

Do you avoid certain foods? Yes/No. If so, why? __________________________________

____

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

____

Do you experience any symptoms after meals? Explain: ______________________________

____

Comments: ____

____

FEE SCHEDULE:

Initial visit (60-90 minutes): $297
Follow up visit (45-60 minutes): $149

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered.

CLIENT STATEMENT:
I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Client Name: ____
Signature: _________________________________ Date: ___________________________

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

The NUTRI-SYSTEMS PROFILE (NSP)

Nutritional Assessment by Body Systems

NSP CLIENT ASSESSMENT FORM

NAME: ____ AGE:_______ DATE: _________________

COMPLETE LEFT SIDE OF FORM ONLY: If any of the following symptoms or activities have occurred *within the past three months* (unless otherwise specified), please indicate by checking: **1** for mild or rarely occurring, **2** for moderate or regularly occurring, **3** for severe or often occurring, or **leave blank** if the symptom/statement does not apply.

Please complete this section				**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	General fatigue or weakness		Right Side for Office Use Only										
2	Difficulty losing weight												
3	Frequent illness/infections												
4	High stress Lifestyle												
5	Smoking												
6	Drinking more than 2 cups of coffee/day												
7	Bad breath and/or body odour												
8	Constipation												
9	Bags under eyes												
10	Crave sugars, bread, alcohol												
11	Difficulty digesting certain foods												
12	Have used antibiotics in past 10 years												
13	Allergies												
14	Poor concentration or memory												
15	Belching or burping after meals												
16	Skin/complexion problems												
17	Frequent consumption of red meat												
18	Regular use of dairy products												
19	Heavy alcohol consumption												
20	Exposure to toxins/chemicals												
21	Frequent mood swings												
22	Depressed and/or irritable												
23	Brittle fingernails												
24	Dry, brittle hair, split ends												
25	High fat/high cholesterol diet												
26	Nervousness/anxiety/tension/worry												
27	Insomnia/restless sleep												
28	Low fibre diet												
29	Muscle cramps												
30	Sleepy when sitting up												
31	Female: menstrual cramps												
32	Bronchitis/asthma/pneumonia/emphysema												
33	Cellulite												
34	Cold hands and feet												
35	Varicose veins												
36	Feeling out of control												
37	Food/chemical sensitivities												
38	Frequent yeast/fungus problems												
39	Bones break easily, osteoporosis												
40	Too little exercise												
	SCORES SUBTOTAL												

NAME: ______________________ DATE: _______________ ASSESSMENT# ________

(**Check: 1** for mild or rarely occurring, **2** for moderate or regularly occurring, **3** for severe or often occurring, or **leave blank** if the symptom/statement does not apply.)

Please complete this section			Right Side for Office Use Only	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	SUBTOTALS												
41	Excessive mucous												
42	Short of breath climbing stairs												
43	Tingling in lips, fingers, arms, legs												
44	Chest pains												
45	Very rapid or slow heart beat												
46	Painful, hard or thin bowel movements												
47	Alternating constipation/diarrhea												
48	Recurrent bladder infections												
49	Female: Menopause, hot flashes												
50	Female: PMS												
51	Difficult urination												
52	Swollen glands, puffy throat												
53	Lower abdominal pain												
54	Frequent need to urinate												
55	Joint pain												
56	Sinus inflammation/discharge												
57	Arthritis												
58	Sudden weight gain/loss												
59	Headaches/Migraines												
60	Female: Taking birth control pills												
61	Lower back pains												
62	Dry, flaky skin												
63	Drink less than 6 glasses of fluids/day												
64	Water retention												
65	Low sex drive												
66	Feeling heavy/bloated after meals												
67	Chronic cough												
SCORES TOTAL													

SYSTEMS RATING TABLE: For Office Use Only

1.	Digestive	
2.	Intestinal	
3.	Circulatory/Cardiovascular	
4.	Nervous	
5.	Immune/Lymphatic	
6.	Respiratory	
7.	Urinary	
8.	Glandular/Endocrine	
9.	Structural	
10.	Reproductive	

COMMENTS:

Seven Day Food Diary

Please roughly record your typical intake for 7 days **Client:__________________________________** **Date: ______________**

Meal	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Breakfast							
Mid Morning Snack							
Lunch							
Mid Afternoon Snack							
Dinner							
Evening Snack							
Noticeable symptoms – physical or emotional							

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