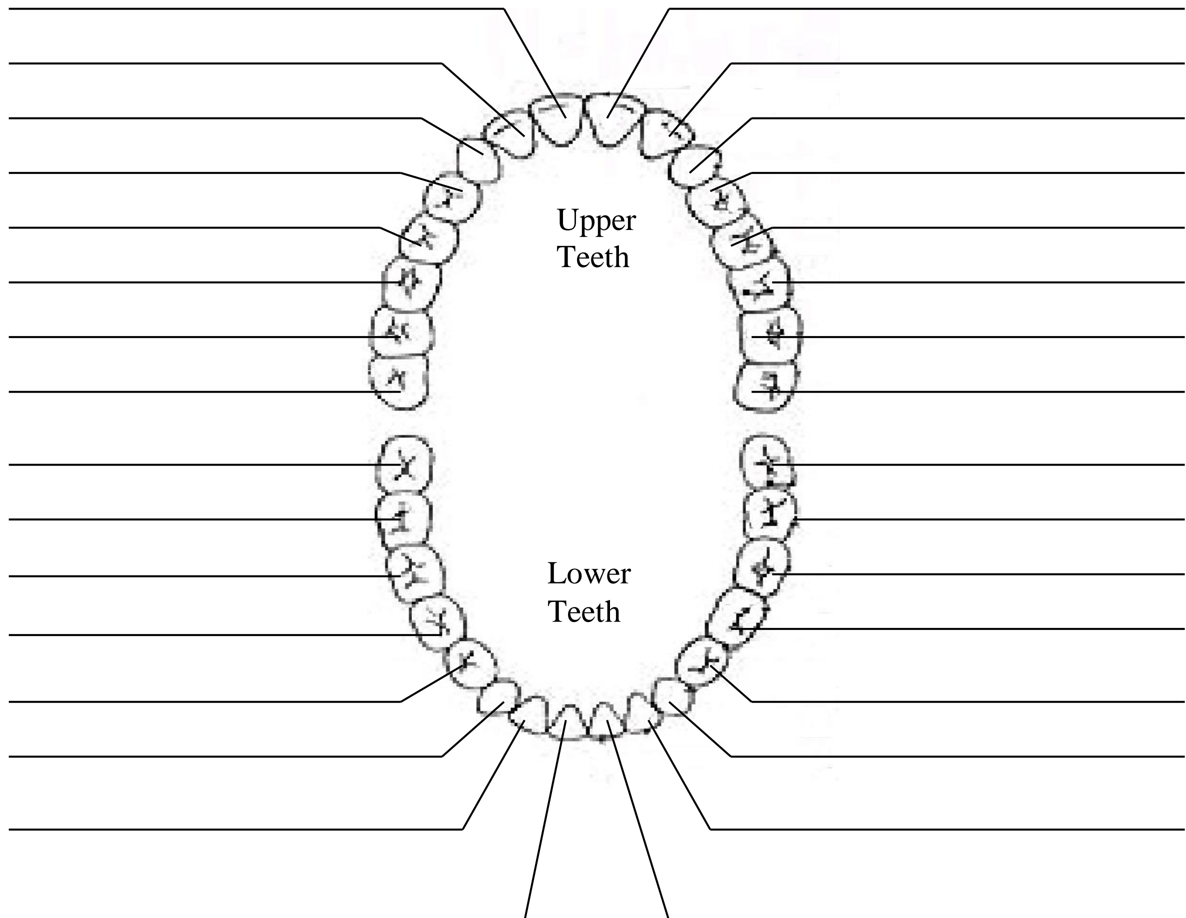
DENTAL HISTORY
WEBER CHIROPRACTIC & NUTRITIONAL HEALING

Name: ________________________________ Date: ________________

DIRECTIONS: Please fill out the chart by briefly describing what kind of dental work has been done on each tooth and the approximate age you were at the time. Please include the following if you have undergone these procedures:

- ☐ Silver fillings
- ☐ Composite or porcelain fillings
- ☐ Gold fillings or crowns
- ☐ Root canals
- ☐ Veneers
- ☐ Bridge
- ☐ Dentures
- ☐ Extracted teeth



WEBER CHIROPRACTIC
& NUTRITIONAL HEALING

Fragrance-Free Environment

Due to the sensitivities of our patients and employees, we ask that you do not wear any scented lotions, perfumes, after shave lotions, colognes or body sprays to our office. It is our goal to ensure that we have an environment that is conducive to health and wellness. Many people respond to these products in a negative way, causing reactions such as headaches, coughing, scratchy throat or nausea to name a few. If you choose to do so, it may be necessary to reschedule your appointment.

Thank You in advance,

Weber Chiropractic and Nutritional Healing

Patient Signature: ___________________________ Date:_______________

WEBER CHIROPRACTIC & NUTRITIONAL HEALING

New Client Evaluation

Today's Date____________________ Referred by:____

Name____ M F Birthdate______/_______/______

Mailing Address____

City____________________________________ State ______________ Zip Code___________________

Daytime Phone_________________________________ Evening Phone __________________________

Occupation_______________________________________ Marital Status S M D W

No. of Children___________ Email address ____

Complaints: Please tell us the main reason why you are here today______________________________

____

Secondary Complaints: Please let us know any other health concerns that you have ________________

____

Previous Treatment for These Complaints:____

____

Medications: Please list all prescription medications you are taking_______________________________

____

Major Illnesses: Please list any major illnesses and approximate dates_____________________________

____

Surgeries: Please list any major surgeries and approximate dates__________________________________

____

Injuries: Please list any accidents or injuries and approximates dates______________________________

____

(over)

Sleep: (please circle) trouble falling asleep can't stay asleep bad dreams

Any other sleep problems? ____

Pets: Any pets? ___________ if so, what kind and how many? _________________________________

Exercise: What kind of exercise do you do? ____

How often? _____________________________ Duration ______________________________________

Food allergies: Please list ____

Food Cravings: Please circle answers to the following questions about food cravings. Regardless of whether or not you let yourself eat these foods.

a. If you could have any breakfast that you wanted, which would you choose?

   Poached eggs with hollandaise sauce
   Bacon and eggs
   Granola and yogurt
   Toast and oatmeal and coffee or tea

b. If you could have any lunch that you wanted, which would you choose?

   Barbecued ribs or teriyaki and chips
   Hamburger and French fries
   A cheese sandwich and/or milkshake
   A sandwich, pretzels and a soda or coffee

c. If you could have any dinner that you wanted, which would you choose?

   Thai food
   A nice steak
   Pizza
   Pasta and sauce

WOMEN ONLY:

Are you pregnant? _________Are you nursing? ________ Date of last menstrual period_______________

Any gynecologic surgeries (hysterectomy, endometriosis, ovarian cysts?) __________________________

____

Menstrual Cycle: Do you have regular monthly periods? _______________________________________

Circle any of the following symptoms you experience associated with your period:

cramping bloating weakness mood swings cravings

heavy bleeding back pain headaches clots

Other symptoms ____

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a purification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting 0 1 2 3 4
b. Diarrhea 0 1 2 3 4
c. Constipation 0 1 2 3 4
d. Bloated feeling 0 1 2 3 4
e. Belching and/or passing gas 0 1 2 3 4
f. Heartburn 0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears 0 1 2 3 4
b. Earaches or ear infections 0 1 2 3 4
c. Drainage from ear 0 1 2 3 4
d. Ringing in ears or hearing loss 0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings 0 1 2 3 4
b. Anxiety, fear, or nervousness 0 1 2 3 4
c. Anger, irritability 0 1 2 3 4
d. Depression 0 1 2 3 4
e. Sense of despair 0 1 2 3 4
f. Uncaring or disinterested 0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness 0 1 2 3 4
b. Hyperactivity 0 1 2 3 4
c. Restlessness 0 1 2 3 4
d. Insomnia 0 1 2 3 4
e. Startled awake at night 0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes 0 1 2 3 4
b. Swollen, reddened, or sticky eyelids 0 1 2 3 4
c. Dark circles under eyes 0 1 2 3 4
d. Blurred or tunnel vision 0 1 2 3 4

Total: ____

6. HEAD

a. Headaches 0 1 2 3 4
b. Faintness 0 1 2 3 4
c. Dizziness 0 1 2 3 4
d. Pressure 0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion 0 1 2 3 4
b. Asthma or bronchitis 0 1 2 3 4
c. Shortness of breath 0 1 2 3 4
d. Difficulty breathing 0 1 2 3 4

Total: ____

8. MIND

a. Poor memory 0 1 2 3 4
b. Confusion 0 1 2 3 4
c. Poor concentration 0 1 2 3 4
d. Poor coordination 0 1 2 3 4
e. Difficulty making decisions 0 1 2 3 4
f. Stuttering, stammering 0 1 2 3 4
g. Slurred speech 0 1 2 3 4
h. Learning disabilities 0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing 0 1 2 3 4
b. Gagging or frequent need to clear throat 0 1 2 3 4
c. Swollen or discolored tongue, gums, lips 0 1 2 3 4
d. Canker sores 0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose 0 1 2 3 4
b. Sinus problems 0 1 2 3 4
c. Hay fever 0 1 2 3 4
d. Sneezing attacks 0 1 2 3 4
e. Excessive mucous 0 1 2 3 4

Total: ____

11. SKIN

a. Acne 0 1 2 3 4
b. Hives, rashes, or dry skin 0 1 2 3 4
c. Hair loss 0 1 2 3 4
d. Flushing 0 1 2 3 4
e. Excessive sweating 0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats 0 1 2 3 4
b. Rapid heartbeats 0 1 2 3 4
c. Chest pain 0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints 0 1 2 3 4
b. Rheumatoid arthritis 0 1 2 3 4
c. Osteoarthritis 0 1 2 3 4
d. Stiffness or limited movement 0 1 2 3 4
e. Pain or aches in muscles 0 1 2 3 4
f. Recurrent back aches 0 1 2 3 4
g. Feeling of weakness or tiredness 0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking 0 1 2 3 4
b. Craving certain foods 0 1 2 3 4
c. Excessive weight 0 1 2 3 4
d. Compulsive eating 0 1 2 3 4
e. Water retention 0 1 2 3 4
f. Underweight 0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness 0 1 2 3 4
b. Frequent or urgent urination 0 1 2 3 4
c. Leaky bladder 0 1 2 3 4
d. Genital itch, discharge 0 1 2 3 4

Total: ____

Section I Total: ____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

Question	Rating
a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)	0 1 2 3 4
b. How often are pesticides used in your home?	0 1 2 3 4
c. How often do you have your home treated for insects?	0 1 2 3 4
d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?	0 1 2 3 4
e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics?	0 1 2 3 4
f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	0 1 2 3 4

Total: ________

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

Question	Rating
a. Have you noticed any negative change in your health since you moved into your home or apartment?	0 1 2 3
b. Have you noticed any change in your health since you started your new job?	0 1 2 3

Total: ________

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

Question	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: ________

Section II Total: ________

Grand Total (Section I & Section II) ________________

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a purification program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.

Symptom Survey

What to fill out

Instructions

- Please circle any of the symptoms you've had within the last 6 months Circle
  - 1. Mild
  - 2. Mediocre
  - 3. Severe
- When you complete this form, you will talk ***privately with the Doctor*** to discuss your health problems and any concerns you may have
- An appropriate care plan will be discussed and may require further testing, necessary to determine the precise cause of your health problems.
- You will be ***scheduled*** for a ***follow up call or visit,*** to go over the results of this information along with any recommendations for treatment and any other consultations.

SYSTEMS SURVEY FORM
(Restricted to Professional Use)

PATIENT____________________________________ AGE_______ DOCTOR________________________________ DATE_______________

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, leave it blank**.
Circle either: **(1)** for **MILD** symptoms (occurs rarely), **(2)** for **MODERATE** symptoms (occurs several times a month), or **(3)** for **SEVERE** symptoms (occurs almost constantly).

GROUP ONE

1 – 1 2 3 Acid foods upset
2 – 1 2 3 Get chilled, often
3 – 1 2 3 “Lump” in throat
4 – 1 2 3 Dry mouth-eyes-nose
5 – 1 2 3 Pulse speeds after meal
6 – 1 2 3 Keyed up - fail to calm
7 – 1 2 3 Cuts heal slowly
8 – 1 2 3 Gag Easily
9 – 1 2 3 Unable to relax, startles easily
10 – 1 2 3 Extremities cold, clammy
11 – 1 2 3 Strong light irritates
12 – 1 2 3 Urine amount reduced
13 – 1 2 3 Heart pounds after retiring
14 – 1 2 3 “Nervous” stomach
15 – 1 2 3 Appetite reduced
16 – 1 2 3 Cold sweats often
17 – 1 2 3 Fever easily raised
18 – 1 2 3 Neuralgia-like pains
19 – 1 2 3 Staring, blinks little
20 – 1 2 3 Sour stomach frequent

GROUP TWO

21 – 1 2 3 Joint stiffness after arising
22 – 1 2 3 Muscle-leg-toe cramps at night
23 – 1 2 3 “Butterfly” stomach, cramps
24 – 1 2 3 Eyes or nose watery
25 – 1 2 3 Eyes blink often
26 – 1 2 3 Eyelids swollen, puffy
27 – 1 2 3 Indigestion soon after meals
28 – 1 2 3 Always seem hungry; feels “lightheaded” often
29 – 1 2 3 Digestion rapid
30 – 1 2 3 Vomiting frequent
31 – 1 2 3 Hoarseness frequent
32 – 1 2 3 Breathing irregular
33 – 1 2 3 Pulse slow; feels “irregular”
34 – 1 2 3 Gagging reflex slow
35 – 1 2 3 Difficulty swallowing
36 – 1 2 3 Constipation, diarrhea alternating
37 – 1 2 3 “Slow starter”
38 – 1 2 3 Get “chilled” infrequently
39 – 1 2 3 Perspire easily
40 – 1 2 3 Circulation poor, sensitive to cold
41 – 1 2 3 Subject to colds, asthma, bronchitis

GROUP THREE

42 – 1 2 3 Eat when nervous
43 – 1 2 3 Excessive appetite
44 – 1 2 3 Hungry between meals
45 – 1 2 3 Irritable before meals
46 – 1 2 3 Get “shaky” if hungry
47 – 1 2 3 Fatigue, eating relieves
48 – 1 2 3 “Lightheaded” if meals delayed
49 – 1 2 3 Heart palpitates if meals missed or delayed
50 – 1 2 3 Afternoon headaches
51 – 1 2 3 Overeating sweets upsets
52 – 1 2 3 Awaken after few hours sleep - hard to get back to sleep
53 – 1 2 3 Crave candy or coffee in afternoons
54 – 1 2 3 Moods of depression - “blues” or melancholy
55 – 1 2 3 Abnormal craving for sweets or snacks

GROUP FOUR

56 – 1 2 3 Hands and feet go to sleep easily, numbness
57 – 1 2 3 Sigh frequently, “air hunger”
58 – 1 2 3 Aware of “breathing heavily”
59 – 1 2 3 High altitude discomfort
60 – 1 2 3 Opens windows in closed room
61 – 1 2 3 Susceptible to colds and fevers
62 – 1 2 3 Afternoon “yawner”
63 – 1 2 3 Get “drowsy” often
64 – 1 2 3 Swollen ankles worse at night
65 – 1 2 3 Muscle cramps, worse during exercise; get “charley horses”
66 – 1 2 3 Shortness of breath on exertion
67 – 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion
68 – 1 2 3 Bruise easily, “black and blue” spots
69 – 1 2 3 Tendency to anemia
70 – 1 2 3 “Nose bleeds” frequent
71 – 1 2 3 Noises in head, or “ringing in ears”
72 – 1 2 3 Tension under the breastbone, or feeling of “tightness”, worse on exertion

GROUP FIVE

73 – 1 2 3 Dizziness
74 – 1 2 3 Dry skin
75 – 1 2 3 Burning feet
76 – 1 2 3 Blurred vision
77 – 1 2 3 Itching skin and feet
78 – 1 2 3 Excessive falling hair
79 – 1 2 3 Frequent skin rashes
80 – 1 2 3 Bitter, metallic taste in mouth in mornings
81 – 1 2 3 Bowel movements painful or difficult
82 – 1 2 3 Worrier, feels insecure
83 – 1 2 3 Feeling queasy; headache over eyes
84 – 1 2 3 Greasy foods upset
85 – 1 2 3 Stools light-colored
86 – 1 2 3 Skin peels on foot soles
87 – 1 2 3 Pain between shoulder blades
88 – 1 2 3 Use laxatives
89 – 1 2 3 Stools alternate from soft to watery
90 – 1 2 3 History of gallbladder attacks or gallstones
91 – 1 2 3 Sneezing attacks
92 – 1 2 3 Dreaming, nightmare type bad dreams
93 – 1 2 3 Bad breath (halitosis)
94 – 1 2 3 Milk products cause distress
95 – 1 2 3 Sensitive to hot weather
96 – 1 2 3 Burning or itching anus
97 – 1 2 3 Crave sweets

GROUP SIX

98 – 1 2 3 Loss of taste for meat
99 – 1 2 3 Lower bowel gas several hours after eating
100 – 1 2 3 Burning stomach sensations, eating relieves
101 – 1 2 3 Coated tongue
102 – 1 2 3 Pass large amounts of foul-smelling gas
103 – 1 2 3 Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours after
104 – 1 2 3 Mucous colitis or “irritable bowel”
105 – 1 2 3 Gas shortly after eating
106 – 1 2 3 Stomach “bloating” after eating

GROUP SEVEN

(A)

107 – 1 2 3 Insomnia
108 – 1 2 3 Nervousness
109 – 1 2 3 Can’t gain weight
110 – 1 2 3 Intolerance to heat
111 – 1 2 3 Highly emotional
112 – 1 2 3 Flush easily
113 – 1 2 3 Night sweats
114 – 1 2 3 Thin, moist skin
115 – 1 2 3 Inward trembling
116 – 1 2 3 Heart palpitates
117 – 1 2 3 Increased appetite without weight gain
118 – 1 2 3 Pulse fast at rest
119 – 1 2 3 Eyelids and face twitch
120 – 1 2 3 Irritable and restless
121 – 1 2 3 Can’t work under pressure

(B)

122 – 1 2 3 Increase in weight
123 – 1 2 3 Decrease in appetite
124 – 1 2 3 Fatigue easily
125 – 1 2 3 Ringing in ears
126 – 1 2 3 Sleepy during day
127 – 1 2 3 Sensitive to cold
128 – 1 2 3 Dry or scaly skin
129 – 1 2 3 Constipation
130 – 1 2 3 Mental sluggishness
131 – 1 2 3 Hair coarse, falls out
132 – 1 2 3 Headaches upon arising wear off during day
133 – 1 2 3 Slow pulse, below 65
134 – 1 2 3 Frequency of urination
135 – 1 2 3 Impaired hearing
136 – 1 2 3 Reduced initiative

(C)

137 – 1 2 3 Failing memory
138 – 1 2 3 Low blood pressure
139 – 1 2 3 Increased sex drive
140 – 1 2 3 Headaches, “splitting or rendering” type
141 – 1 2 3 Decreased sugar tolerance

(D)

142 – 1 2 3 Abnormal thirst
143 – 1 2 3 Bloating of abdomen
144 – 1 2 3 Weight gain around hips or waist
145 – 1 2 3 Sex drive reduced or lacking
146 – 1 2 3 Tendency to ulcers, colitis
147 – 1 2 3 Increased sugar tolerance
148 – 1 2 3 Women: menstrual disorders
149 – 1 2 3 Young girls: lack of menstrual function

(E)

150 – 1 2 3 Dizziness
151 – 1 2 3 Headaches
152 – 1 2 3 Hot flashes
153 – 1 2 3 Increased blood pressure
154 – 1 2 3 Hair growth on face or body (female)
155 – 1 2 3 Sugar in urine (not diabetes)
156 – 1 2 3 Masculine tendencies (female)

(F)

157 – 1 2 3 Weakness, dizziness
158 – 1 2 3 Chronic fatigue
159 – 1 2 3 Low blood pressure
160 – 1 2 3 Nails, weak, ridged
161 – 1 2 3 Tendency to hives
162 – 1 2 3 Arthritic tendencies
163 – 1 2 3 Perspiration increase
164 – 1 2 3 Bowel disorders
165 – 1 2 3 Poor circulation
166 – 1 2 3 Swollen ankles
167 – 1 2 3 Crave salt
168 – 1 2 3 Brown spots or bronzing of skin
169 – 1 2 3 Allergies - tendency to asthma
170 – 1 2 3 Weakness after colds, influenza
171 – 1 2 3 Exhaustion - muscular and nervous
172 – 1 2 3 Respiratory disorders

GROUP EIGHT

173 – 1 2 3 Muscle weakness
174 – 1 2 3 Lack of Stamina
175 – 1 2 3 Drowsiness after eating
176 – 1 2 3 Muscular soreness
177 – 1 2 3 Rapid heart beat
178 – 1 2 3 Hyper-irritable
179 – 1 2 3 Feeling of a band around your head
180 – 1 2 3 Melancholia (feeling of sadness)
181 – 1 2 3 Swelling of ankles
182 – 1 2 3 Diminished urination
183 – 1 2 3 Tendency to consume sweets or carbohydrates

184 – 1 2 3 Muscle spasms
185 – 1 2 3 Blurred vision
186 – 1 2 3 Loss of muscular control
187 – 1 2 3 Numbness
188 – 1 2 3 Night sweats
189 – 1 2 3 Rapid digestion
190 – 1 2 3 Sensitivity to noise
191 – 1 2 3 Redness of palms of hands and bottom of feet
192 – 1 2 3 Visible veins on chest and abdomen
193 – 1 2 3 Hemorrhoids
194 – 1 2 3 Apprehension (feeling that something bad is going to happen)
195 – 1 2 3 Nervousness causing loss of appetite
196 – 1 2 3 Nervousness with indigestion
197 – 1 2 3 Gastritis
198 – 1 2 3 Forgetfulness
199 – 1 2 3 Thinning hair

FEMALE ONLY

200 – 1 2 3 Very easily fatigued
201 – 1 2 3 Premenstrual tension
202 – 1 2 3 Painful menses
203 – 1 2 3 Depressed feelings before menstruation
204 – 1 2 3 Menstruation excessive and prolonged
205 – 1 2 3 Painful breasts
206 – 1 2 3 Menstruate too frequently
207 – 1 2 3 Vaginal discharge
208 – 1 2 3 Hysterectomy/ovaries removed
209 – 1 2 3 Menopausal hot flashes
210 – 1 2 3 Menses scanty or missed
211 – 1 2 3 Acne, worse at menses
212 – 1 2 3 Depression of long standing

MALE ONLY

213 – 1 2 3 Prostate trouble
214 – 1 2 3 Urination difficult or dribbling
215 – 1 2 3 Night urination frequent
216 – 1 2 3 Depression
217 – 1 2 3 Pain on inside of legs or heels
218 – 1 2 3 Feeling of incomplete bowel evacuation
219 – 1 2 3 Lack of energy
220 – 1 2 3 Migrating aches and pains
221 – 1 2 3 Tire too easily
222 – 1 2 3 Avoids activity
223 – 1 2 3 Leg nervousness at night
224 – 1 2 3 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent ____________ Standing ____________ Pulse ____________

Hema-Combistix Urine readings: pH ____________ Albumin per cent ____________ Glucose per cent ____________

Occult Blood ____________ pH of Saliva ____________ pH of Stool specimen ____________ Weight ____________

Hemoglobin ____________ Blood Clotting Time ____________

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES
Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES
The 2nd and 3rd day of flow OR any 5 days in a row.

MALES
Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date: ____________ Temperature: ____________
Date: ____________ Temperature: ____________
Date: ____________ Temperature: ____________
Date: ____________ Temperature: ____________
Date: ____________ Temperature: ____________
Date: ____________ Temperature: ____________
Date: ____________ Temperature: ____________

Diet Diary

What to fill out

Instructions

- Write down everything and anything you have eaten within the last 5-7 days
  - Please list anything that you put in your mouth, i.e. gum, candies, etc
- When you complete this form, you will talk ***privately with the Doctor*** to discuss your health problems and any concerns you may have
- An appropriate care plan will be discussed and may require further testing, necessary to determine the precise cause of your health problems.
- You will be ***scheduled*** for a ***follow up call or visit,*** to go over the results of this information along with any recommendations for treatment and any other consultations.

Daily Record of Food Intake | *Your diet may be the key to better health.*

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.

Name: ______________________

Day 1 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 2 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 3 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Notes: ______________________

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Day 4 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

Day 5 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

Day 6 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

Day 7 - Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	**MID-DAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel Movements *(# and consistency):*	**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)