Nutrition Profile

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately these questions. Health issues are usually influenced by many factors. These have a direct impact on your wellness, training, and energy level.

To enhance your scheduled consult time, please have this back to us at least 2 days prior to your appointment. You can email it back to wellness@spaongreenstreet.com.

Date _____ Referred by _____

First Name _____ MI _____ Last Name _____

Birth Date _____ Age _____ M / F Height_____ Weight _____ Last age at desired weight _____

Mailing Address_____

City _____ State _____ Zip _____

Home Phone _____Cell _____ Business Phone _____

Email _____

What are your reasons and goals for nutrition and wellness counseling?

Provide a general description of your daily routine, employment, and your hours:

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General History

Do you have any known **food allergies/intolerances/sensitivities**? Please list all.

Please list name and dose of **all medical prescriptions,** dosages, and reason why you take each medicine.

Medication Name	Purpose	Dosage	Start Date

Any additional medications:

Please list name and dose of **all supplements,** herbs, medical prescriptions, or special diet/sport aids. Include name brand, amount, and reason why for each supplement. **BRING YOUR BOTTLES WITH YOU TO YOUR VISIT**

vitamin/herb	brand	how many / when	start date

vitamin/herb	brand	how many / when	start date

Any additional supplements:

Have you had a blood test or health screen in the past year? _____Yes _____No

Did your testing indicate and **"high" or "low"** normal values? **Please send all current results from testing in the past year (email wellness@spaongreenstreet.com)**

Was there any noteworthy medical diagnosis?

Alcohol Intake? ____Yes ____No
Please say how much, type, and frequency

Smoking? ____Yes ____No

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Please describe

Drug Use? ___Yes___No

Name of Primary Physician _____ Phone _____

Names of other practitioners, therapists, coaches, and contact information: May we contact? ___Yes ___No

	When	Comments
Acne		
Alzheimer's disease		
Anemia (type)		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Chronic Kidney Disease -Please list GFR _____		
Crohn's Disease or Ulcerative Colitis		
Diabetes Please list last A1C level: _____		
Diverticulitis/ Diverticulosis		
Eczema		
Endometriosis		
Emphysema		
Epilepsy, Convulsions or Seizures		
Fibrocystic Breasts		
Gallstones		
General Cognitive Decline		
Gout		

	When	Comments
Heart Attack/Angina		
Heart Failure		
Hepatitis		
High Blood Fats (cholesterol, triglycerides)		
High Blood Pressure (hypertension)		
Insomnia		
Irritable Bowel		
Kidney stones		
Mononucleosis		
Pancreatitis		
Parkinson's Disease		
Polycystic Ovarian Syndrome		
Premenstrual Syndrome		
Psoriasis		
Pneumonia		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid Disease		
Uterine Fibroids		
Other (describe)		
AUTOIMMUNE DISEASE		

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	When	Comments
Rheumatoid Arthritis		
Lupus		
Scleroderma		
Multiple Sclerosis		
Mixed Connective Tissue Disease		
Hashimoto's Thyroiditis		
Other (describe)		
INJURIES		
Back Injury		
Broken Bones		
Head Injury		
Neck Injury		
Other (acute) ex: sprained muscle		
Other (chronic) ex: bad knees		
DIAGNOSTIC STUDIES		
Bone Scan (DEXA)		
CAT Scan		
EKG		
MRI		
Upper/Lower GI Series		
Other (describe)		
OPERATIONS		
Dental Surgery		
Gallbladder		
Hysterectomy		
Tonsillectomy		

	When	Comments
Heart Surgery		
Organ Transplant		
Bowel Resection		
Gastric Bypass		
Sinus Surgery		
Spinal Surgery		
Hip Replacement		
Knee Surgery		
Other (describe)		

Past Medical and Surgical History

4. Please indicate significant family medical history (ex: cancer, diabetes, heart disease, etc.)

Maternal side:

Paternal side:

5. Did you have any health issues as a child? _____Yes _____No What age? _____
Describe:

Are there any foods that you avoided as a child? Please list and symptoms.

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Reproductive & Gastro-Urinary Health

Please mark in the chart below with information about recent bowel movements:

Frequency	Color	Consistency
__More than 3 times a day __2-3 times a day __One time per day __4-6 times a week __2-3 times a week __Once or fewer a week	__Dark brown __Medium brown __Very dark or black __Greenish __Yellow, light brown __Blood is visible __Varies a lot	__Soft and well formed __Greasy, shiny appearance __Often float __Difficult to pass __Diarrhea __Thin, long or narrow __Small and hard __Loose, but not watery __Alternating between hard and loose/watery

Do you experience intestinal gas? (check all that apply)
____present with pain _____foul smell _____little odor _____excessive daily _____occasionally

Do you experience anal itching? _____frequently _____occasionally _____rarely _____never

Do you experience any heartburn, chest pressure, or stomach pain? _____No _____Yes
If yes, do you take anything for relief (list):

<u>WOMEN ONLY:</u>

Age of first menses: _____

Date of last Pap Smear: _____ ____ Normal ___ Abnormal

Date of last Mammogram: _____ ____Normal ____Abnormal

Do you currently use contraception? _____ No _____ Yes (type)_____

Are you currently taking birth control pills? ____No ___ Yes (how long?) _____

If you are currently on the birth control, please comment on any physical or mental changes from before taking them up to now:

Do you currently experience PMS (i.e. water retention, breast tenderness, irritability, etc.)? _____No _____Yes

(specify)_____

Have you ever experienced PMS in the past? ____ No ____Yes When? _____

Are you still menstruating? ____ Yes ____ No - (age of last period: _____)

Are you experiencing menopause symptoms? ____No ____Yes

Do you take: _____Estrogen _____Estrace _____Premarin _____Other-(specify)_____

Have you ever been pregnant? ___ No ___Yes If yes, please answer the following:

Number of miscarriages: _____ Number of abortions: _____ Number of preemies: _____

Number of term births: _____ Birth weight of largest baby: _____ Smallest baby: _____

Did you develop toxemia? ____ No ____Yes
Have you had any other problems with pregnancy? ____ No ____Yes
If yes, describe:

MEN & WOMEN:
Do you have urinary problems? ____No ____ Yes

If yes, please specify: ____ Nightly urination ____ Frequent day time urination ____ Hesitancy Irregular

____ Dribbling afterwards ____ Frequent urge to urinate ____ Difficulty ____Feeling of incomplete emptying

____Burning sensation

MEN ONLY:
Do you have prostate swelling? ___ No ___Yes

Write out a summary (as short or as long you would like it to be) of your health history. Please include any prior surgeries you may have had.

Initial Symptom Survey

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Date	Name	Dietitian

INSTRUCTIONS: Score every symptom based on your experience over the Past Month. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for EVERY symptom listed. Note score in the boxes to the left of symptoms. Also note the number of missed work days in the last month due to illness

SCALE OF SYMPTOM POINTS IF you did not suffer from the symptom ever or almost never, leave it blank. 1 = OCCASIONALLY (less than 2 times per week), and symptom was MILD 2 = FREQUENTLY (2 or more times per week), and symptom was MILD 3 = OCCASIONALLY (less than 2 times per week), and symptom was SEVERE 4 = FREQUENTLY (2 or more times per week), and symptom was SEVERE	Grand Total:	Numbers of missed work days:

CONSTITUTIONAL _____Fatigue (sluggish, tired) _____Hyperactive (nervous energy) _____Restless (can't relax/sit still) _____Daytime sleepiness _____Insomnia at night _____Malaise (feeling lousy) _____Seizures _____TOTAL (0-28) EMOTIONAL/MENTAL _____Depression _____Anxiety (fears, uneasiness) _____Mood swings (rapid changes) _____Irritability _____Forgetfulness _____Lack of concentration/Brain fog _____Low sex drive _____TOTAL (0-28) HEAD/EARS _____Headache (not migraine) _____Migraine _____Earache _____Ear infection _____Ringing in ears _____Itchy ears _____Discharge from ears _____Sensitivity to sound _____TOTAL (0-32) SKIN	NASAL/SINUS _____Post nasal drip _____Sinus pain _____Runny nose _____Stuffy nose _____Sneezing _____TOTAL (0-20) MOUTH/THROAT _____Sore throat _____Swollen throat _____Swelling/burning lips/tongue _____Gagging/throat clearing _____Canker sores _____Difficulty swallowing _____TOTAL (0-24) LUNGS _____Wheezing _____Chest congestion _____Dry cough _____Wet cough _____Shortness of breath _____TOTAL (0-20) EYES _____Red or swollen eyes _____Watery eyes _____Itchy eyes _____Dark circles or "bags" _____Sensitivity to light _____Aura _____TOTAL (0-24) GENITOURINARY	MUSCULOSKELETAL _____Joint pains _____Stiff joints _____Muscle aches _____Stiff muscles _____Ticks (facial or otherwise) _____Muscle spasms _____Muscle cramps _____TOTAL (0-28) CARDIOVASCULAR _____Irregular heartbeat _____High blood pressure _____TOTAL (0-8) DIGESTIVE _____Heartburn/reflux _____Stomach pains/cramps _____Intestinal pains/cramps _____Constipation _____Diarrhea _____Bloating sensation _____Gas (of any kind) _____Nausea _____Vomiting _____Painful elimination _____TOTAL (0-40) WEIGHT MANAGEMENT Current weight: _____Fluctuating weight _____Food cravings _____Water retention _____Binge eating or drinking _____Purging (all methods)

_____Blemishes, acne _____Rashes or hives _____Eczema or psoriasis _____"Rosy" cheeks _____Flushing _____Itchy skin _____TOTAL (0-24)	_____Increased urinary frequency _____Painful urination _____Bladder pain _____Bedwetting _____TOTAL (0-16)	_____TOTAL (0-20) LIST OTHER SYMPTOMS:

Exercise History

Do you exercise regularly? Yes _____No ___ If so, please list exercise, how often, duration, and intensity?

Type of exercise Days/week____ Minutes/Day____ Moderate _____ Vigorous____

Total number of hours per week ____

Injuries or limitations?

Social History

How well have things been going for you lately?

	Great	Good	Could be better	Not very good	Does Not Apply	Comments
school						
job						
social life						
close friends						
sex						
your attitude						

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	Great	Good	Could be better	Not very good	Does Not Apply	Comments
boy/girlfriend						
children						
parents						
spouse						

With whom do you live? List age of children, if any.

What is the attitude of those close to you concerning your health?

_____ Supportive _____ Not supportive _____ Indifferent

Are you currently married, or have you ever been married? No Yes
If yes, when _____ If yes, spouse's occupation: _____

Have you been separated or divorced? ___ No ___ Yes - If yes, when? _____

What are your hobbies and leisure activities?

Describe previous jobs/work:

Have you lived outside of the United States? ___ No ___ Yes
If yes, where/when?

What is your total amount of airline trips, in the last year?

Estimated total in life: _____ How many out of the country: _____

Have you experienced any major losses in your life? ____No ____Yes
If so, please comment:

Have you or your family recently experienced any major life changes (such as a job change)? ___No ___Yes
If yes, please comment:

Have you ever had psychotherapy or counseling? ___ No ___ Yes
If yes, what kind? _____ when? _____

Additional comments:

Stress Level

Self-Assessment of Stress Level: (circle) High Moderate Low
Personality Type: (circle)

Impatient, time-oriented, competitive
Usually somewhat relaxed, sometimes anxious
Relaxed, easy going

What are some of your favorite books?

Describe any current sources of stress OR Any severe personal problems in the past 12 months? (such as death of family member, marital problems, divorce, job changed, accidents, law suits, serious family problems, ill health)

Relaxation Techniques Practiced? Yes ___ No ___ Please explain.

Anthropometric

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Height: _____ Approximate Weight (current): _____ What is your desired weight? _____

Describe any weight changes in the past year.

Nutrition & Daily Intake

Have you had any previous diet or nutritional instruction? ___ Yes ___ No
If so, by whom?

Describe any special meal / diet plan that you follow/ or food preferences.

- ☐ Low fat
- ☐ No gluten
- ☐ No dairy
- ☐ Low carb
- ☐ Vegetarian
- ☐ No Wheat
- ☐ High protein
- ☐ Vegan
- ☐ Weight Loss
- ☐ Low sodium
- ☐ Diabetic
- ☐ Organic
- ☐ Paleo
- ☐ Ketogenic
- ☐ Other (describe):

What are your food preparation habits?

How often do you eat out (at restaurants, fast food, work cafeteria, etc.)?

Do you avoid any of the following foods? (Check all that apply or list any not listed)

- ☐ Red meat
- ☐ Poultry (chicken, turkey)
- ☐ Fish
- ☐ Dairy (milk, cheese)
- ☐ Vegetables
- ☐ Fruits
- ☐ Fried foods
- ☐ Bread
- ☐ Grains (pasta, rice)
- ☐ Fast foods
- ☐ Sweets (candy, desserts)
- ☐ Alcohol
- ☐ Fats/oils (mayo, salad dressing, butter)

What are some of your favorite foods?

What beverages do you drink each day?

What types of diet foods or special sport fuels are you using?

Check all factors that apply to your current lifestyle and eating:

- ☐ Fast Eater
- ☐ Erratic eating Patterns
- ☐ Eating too Much
- ☐ Late night eating
- ☐ Dislikes healthy foods
- ☐ Time constraints
- ☐ Travel frequently
- ☐ Do not plan meals or menus
- ☐ Rely on convenient items
- ☐ Family members have different tastes
- ☐ Love to eat
- ☐ Eat because I have to
- ☐ Have negative relationship with food
- ☐ Struggle with waiting to eat
- ☐ Emotional Eater (stress, bored, etc.)
- ☐ Confused about food/nutrition
- ☐ Frequently eat fast foods
- ☐ Poor snack choices

What are the top three changes do you think would make the overall difference in your health?

1.

2.

3.

How committed are you to making nutritional changes to improve your health? (circle one)

not committed 1 2 3 4 5 vey committed

Sleep habits/ rest/ energy

How many hours of sleep do you get, on average?
During the week: _____ On Weekends: _____

Do you wake up feeling refreshed?

At what times of the day do you feel most productive?

Do you get sleepy after eating?

Do you take naps? _____ If so, do you feel like you need to? _____

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Do you take breaks during the day to help manage stress?

On average, how long does it take for you to fall asleep?

Do you wake up at night and feel stressed?

Have you felt like your strength has significantly declined in the past year?
If so, please describe:

General Notes

Any other comments or information that you feel would be important to share?

By signing below you acknowledges that you have read, understand, and agree to the Integrative Health & Nutrition Coaching Client Agreement, which includes expectations, payment and cancellation policies, and waivers.

_____
Signature of client or legal guardian

_____
Printed Name

_____
Client name if signed by legal guardian

_____
Date

Thank you for taking the time to fill out this form. I look forward to meeting with you!