Sarah Green
Central Coast Alternative Therapeutics and Rejuvenation
671 West Tefft Street #9
Nipomo, CA 93444
Office: (805) 619-7515
Cell: (805) 459-7875
Fax: (805) 249-1906

Functional Medicine
New Patient Intake Form

These forms and your medical records must be submitted to our office at least seven days prior to your first appointment

Did you remember to?

1. Read all of the practice documents?
2. Obtain your medical records and/ or test results from previously seen physicians and have them sent at least seven days prior to your appointment date to:

Sarah Green
CCATR
671 West Tefft Street #9
Nipomo, CA 93444
Fax: (805) 249-1906
Email: sarahgreenccatr@proton.me

Fill out and sign the following forms

1. Important patient information
2. Informed consent regarding email or the internet use of protected personal information
3. Notice of medical denial
4. General questionnaire
5. Medical symptom/ toxicity questionnaire

We are looking forward to working with you to help you achieve your ultimate health goals!

Functional Medicine Fee and Private Membership Association

There is a monthly membership fee of $50.00 which enables you to be seen by Sarah Green. Appointments range anywhere from $200.00 - $400.00 per visit. An additional charge will be applied for any additional services including IV infusions.

Cancellation:

The office requires a 48 hour cancellation notice. We understand that there are times where this is difficult to do. If we are able to fill your spot there will not be a cancellation charge. If we are not able to fill your spot there will be a cancellation charge of $200.00 that will be taken from your payment method on file.

Late Arrivals:

We are committed to being on time with patient's appointments in order to prevent clients from waiting. If you arrive late to the office for your consultation, your appointment will end at the scheduled time and you will be charged for the length of the originally scheduled visit.

Supplements:

Many of the supplements we recommend are available for purchase through our office. Even though we recommend and

work closely with Vintage Labs and Plexus, you are not obligated to purchase these supplements from our office.

Credit Cards:

We require a credit card to be put on file. This credit card will be used to pay your monthly fee and any additional services. Please fill out the credit card form below.

CC # _____ EXP _____ CVV_____ ZIP_____

Follow Up Appointments:

At the time of check out, you will be rescheduled for a follow up appointment if needed. You can also request a follow up appointment at check out if desired.

Payment Options:

Cash, check, and credit cards are all accepted methods of payment for services.

Medical Insurance:

Medical insurance is not accepted at the office, and our office is unable to assist with any claims. In addition, Sarah Green is not a Medicare provider. You will be provided with a billing summary that you can submit to your insurance company. We will not submit it for you.

Office Hours:

Our office hours are:
Monday-Friday from 9:00 AM - 4:00 PM PST

If you call during office hours and we do not pick up the phone, please leave a message with your full name, phone number, and the reason for your call and we will return your call within the next business day. If you have a medical issue that cannot wait until the next business day, you can text the cell number provided above, and Sarah Green will return the text as quickly as possible.

If you are experiencing a medical emergency, please call 9-1-1 or go directly to the emergency room.

Prescription Refill Request:

For prescription refills, please contact your pharmacy and have them fax over the medication refill request. It may take up to 72 business hours to process a prescription refill, so please plan accordingly.

All Medicare Patients MUST Sign This Form

NOTICE OF POSSIBLE MEDICARE DENIAL

Medicare will only pay for services determined to be reasonable and necessary under section 1862 (a) (1) of Medicare Law. If a particular service is considered not acceptable and unnecessary under medicare standards, Medicare will deny payment for those excluded services.

MEDICARE NOTICE

Sarah Green is NOT a Medicare provider; therefore, your payment is due at the time services are provided. Any claims submitted will have to be sent by the patient. Payment reimbursement is not guaranteed and is subject to Medicare eligibility/ reimbursement rules and regulations.

PATIENT ACKNOWLEDGEMENT

My physician, and/ or staff have informed me, that he or she believes services provided will likely be denied by Medicare for reasons stated above.

Signature_____

Print Name_____

Date_____

CCATR provides patients with the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

The risks include:

a. General e-mail risks ae the following:
    1. E-mail can be immediately broadcasted worldwide and be received by many unintended recipients who can forward that e-mail to other recipients without the original sender's permission, or knowledge
    2. Users can easily misaddress an e-mail
    3. E-mail is easier to falsify than handwritten, or signed documents
    4. Backup copies of e-mail may exist even after the sender, or recipient has deleted his or her history
b. Specific e-mail risks are the following:
    1. E-mail containing information pertaining to diagnosis and/ or treatment must be included in the protected personal health information
    2. All individuals who have access to the personal protected health information will have access to the e-mail messages

3. Patients who send, or receive e-mail from their place of employment risk having their employer read their e-mail

c. It is policy of CCATR that all e-mail messages sent or received, which concern diagnosis, or treatment, of the patient will be a part of that patient's protected personal health information and will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. CCATR will use reasonable means to protect the security and confidentiality of e-mail, or internet communication. Due to the risks outlined above, we cannot guarantee the security and confidentiality of e-mail, or internet communications.
d. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
    i. All e-mail to, or from, patients concerning diagnosis and/ or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, Sarah Green, physicians, nurses, other healthcare practitioners, insurance coordinators, and upon written authorization other health care providers and insurers will have access to e-mail messages contained in protected personal health information.

ii. Sarah Green may forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.
iii. Sarah Frost will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail promptly. Therefore, e-mail must not be used in a medical emergency.
iv. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
v. Due to the fact that some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning AIDS/HIV infection, other sexually transmissible, or communicable diseases, behavioral health, mental health, developmental disability, or alcohol and/ or drug abuse.

General Information

Name (First)_____(Last)_____

D.O.B_____ Age_____

Gender (F)_____ (M)_____

Job Title_____

Street Address_____

City_____ State_____ ZIP_____

Phone (Mobile) _____

Phone (Work)_____

Email_____

Fax_____

Emergency Contact_____

Emergency Contact Phone Number _____

Primary Care Doctor_____

Primary Care Doctor Phone Number_____

Allergies_____

Medications / Supplements

_____
_____
_____

Concerns / Complaints

_____
_____
_____

What you want to achieve at your visit

_____
_____
_____

If you had a magic wand, and could erase 3 things, what would they be?

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____

When was the last time you felt well?

_____

_____

Did something trigger this change?

_____

_____

_____

What makes you feel worse?

_____

_____

_____

What makes you feel better?

_____

_____

_____

MEDICAL HISTORY

DISEASE/DIAGNOSIS/CONDITIONS

Check appropriate box and provide date of onset

GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome _____
- ☐ Inflammatory Bowel Syndrome_____
- ☐ Crohn's _____
- ☐ Ulcerative Colitis_____
- ☐ Gastritis or Peptic Ulcer Disease_____

- ☐ GERD (reflux)_____
- ☐ Celiac Disease_____
- ☐ Other_____

CARDIOVASCULAR

- ☐ Heart Attack_____
- ☐ Other Heart Disease_____
- ☐ Stroke_____
- ☐ Elevated Chloesterol_____
- ☐ Arrhythmia (regular heart rate)_____
- ☐ Hypertension (high blood pressure)_____
- ☐ Rheumatic Fever_____
- ☐ Mitral Valve Prolapse_____
- ☐ Other_____

METABOLIC / ENDOCRINE

- ☐ Type 1 Diabeties_____
- ☐ Type 2 Diabeties_____
- ☐ Hypoglycemia_____
- ☐ Metabolic Syndrome_____
- ☐ Insulin Resistance or Pre-Diabeties_____
- ☐ Hypothyroidism (low)_____
- ☐ Hyperthyroidism (high)_____
- ☐ Endocrine Problems_____
- ☐ Polycystic Ovarian Syndrome (PCSO)_____
- ☐ Infertility_____
- ☐ Weight Gain_____
- ☐ Weight Loss_____
- ☐ Frequent Weight Flucuation_____
- ☐ Bulimia_____
- ☐ Anorexia_____
- ☐ Binge Eating Disorder_____
- ☐ Night Eating Syndrome_____

- ☐ Eating Disorder (non-specific)_____
- ☐ Other_____

CANCER

- ☐ Lung Cancer_____
- ☐ Breast Cancer_____
- ☐ Colon Cancer_____
- ☐ Ovarian Cancer_____
- ☐ Prostate Cancer_____
- ☐ Skin Cancer_____

GENERAL AND URINARY SYMPTOMS

- ☐ Kidney Stones_____
- ☐ Gout_____
- ☐ Interstitial Cystitis_____
- ☐ Frequent Urinary Tract Infection_____
- ☐ Frequent Yeast Infections_____
- ☐ Erectile Dysfunction or Sexual Dysfunction_____
- ☐ Other_____

MUSCULOSKELETAL / PAIN

- ☐ Ostheoarthritis_____
- ☐ Fibromyalgia_____
- ☐ Chronic Pain_____
- ☐ Other_____

INFLAMMATORY / AUTOIMMUNE

- ☐ Chronic Fatigue Syndrome_____
- ☐ Autoimmune Disease_____
- ☐ Rheumatoid Arthritis_____
- ☐ Lupus SLE_____
- ☐ Immune Deficiency Disease_____
- ☐ Herpes-Genital_____

- ☐ Severe Infectious Disease_____
- ☐ Poor Immune Function_____
- ☐ Frequent Infections_____
- ☐ Food Allergies_____
- ☐ Environmental Allergies_____
- ☐ Multiple Chemical Sensetivities_____
- ☐ Latex Allergy_____
- ☐ Other_____

RESPIRATORY DISEASE

- ☐ Asthma_____
- ☐ Chronic Sinusitis_____
- ☐ Bronchitis_____
- ☐ Emphysema_____
- ☐ Pneumonia_____
- ☐ Tuberculosis_____
- ☐ Sleep Apnea_____
- ☐ Other_____

SKIN DISEASE

- ☐ Eczma_____
- ☐ Psoriasis_____
- ☐ Acne_____
- ☐ Melanoma_____
- ☐ Skin Cancer_____
- ☐ Other_____

NEUROLOGICAL / MOOD

- ☐ Depression_____
- ☐ Anxiety_____
- ☐ Bipolar Disorder_____
- ☐ Schizophrenia_____
- ☐ Headaches_____

- ☐ Migranes_____
- ☐ ADD/ADHD_____
- ☐ Autism_____
- ☐ Mild Cognitive Impairement_____
- ☐ Memory Problems_____
- ☐ Parkinson's Disease_____
- ☐ Multiple Scleosis_____
- ☐ ALS_____
- ☐ Seizures_____
- ☐ Other Neurological Problems_____

PREVENTIVE TEST AND DATE OF LAST TEST

Check box if *yes* and provide *date*

- ☐ Full Physical Exam_____
- ☐ Bone Density_____
- ☐ Colonoscopy_____
- ☐ Cardiac Stress Test_____
- ☐ EBT Heart Scan_____
- ☐ EKG_____
- ☐ Hemoccult Test (stool test for blood)_____
- ☐ MRI_____
- ☐ CT Scan_____
- ☐ Upper Endoscopy_____
- ☐ Upper GI Series_____
- ☐ Ultrasound_____

INJURIES

- ☐ Back Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Broken Bones

SURGERIES

Check box if *yes* and provide *date*

- ☐ Appendectomy_____
- ☐ Hysterectomy_____
- ☐ Gall Bladder_____
- ☐ Hernia_____
- ☐ Tonsillectomy_____
- ☐ Dental Surgery_____
- ☐ Joint Replacement_____
- ☐ Heart Surgery (bypass valve)_____
- ☐ Angioplasty or Stent_____
- ☐ Pacemaker_____
- ☐ Other_____
- ☐ None_____

BLOOD TYPE

- ☐ A+
- ☐ A-
- ☐ B+
- ☐ B-
- ☐ AB+
- ☐ AB-
- ☐ O+
- ☐ O-
- ☐ RH+
- ☐ Unknown

HOSPITALIZATIONS

- ☐ None

Date:	Reason:

GYNECOLOGIC HISTORY (FOR WOMEN ONLY)

OBSTETRIC HISTORY

- ☐ Pregnancies_____
- ☐ Miscarrige_____
- ☐ Postpartum Depression
- ☐ Breastfeeding_____
- ☐ Caescerian_____
- ☐ Vaginal Deliveries_____
- ☐ Abortions_____
- ☐ Living Children_____
- ☐ Toxemia
- ☐ Gestational Diabetes

MENSTRUAL HISTORY

Age at first period _____Menses Frequency_____ Length (days)_____
Pain (yes or no)_____Clotting (yes or no)_____
Has your period ever skipped_____ For how long_____
Last menstrual period_____
Use of hormonal contraception (if yes, describe)_____
How long (years/months)_____ Do you use contraception?_____
Describe type of contraception used_____

WOMENS DISORDERS / HORMONAL IMBALANCE

- ☐ Fibrocystic Breasts
- ☐ Endometriosis

- ☐ Fibroids
- ☐ Infertility
- ☐ Painful Periods
- ☐ Heavy Periods
- ☐ PMS

Last Mamogram_____ Breast Biopsy Date_____
Last PAP Test_____ Normal?_____
Last Bone Density_____ Results_____
Are you in menopause_____
Age at menopause_____

- ☐ Hot Flashes
- ☐ Mood Swings
- ☐ Conception / Memory Problem
- ☐ Vaginal Dryness
- ☐ Decreased Libido

Do you experience . . .

- ☐ Heavy Bleeding
- ☐ Joint Pains
- ☐ Headach
- ☐ Weight Gain
- ☐ Loss of Control of Urine
- ☐ Palpitations
- ☐ Use of Hormone Replacement Therapy

(How Long?)_____

MEN'S HISTORY (FOR MEN ONLY)

Have you had a PSA done?_____
PSA Level

- ☐ 0-2
- ☐ 2-4
- ☐ 4-10

☐ >10

Do you experience:

- ☐ Prostate Enlargement
- ☐ Prostate Infection
- ☐ Change in Libido
- ☐ Impotence
- ☐ Difficulty Obtaining an Erection
- ☐ Difficulty Maintaining an Erection
- ☐ Nocturia (urination at night)

How many times at night?_____

- ☐ Urgency/Hesitancy/ Change in Urine Stream
- ☐ Loss of Control of Urine

GI HISTORY

- ☐ Foreign Travel (where?)_____
- ☐ Wilderness Camping (where?)_____
- ☐ Severe Gastroenteritis
- ☐ Severe Diarrhea

Do you feel like you digest food well?_____ Do you feel bloated at all?_____

PATIENT BIRTH HISTORY

Full Term or Premature?_____
Pregnancy Complications?_____
Birth Complications?_____
Breast fed(yes or no)_____How long?_____
Bottle fed (yes or no)_____ Age at solid food_____
Age at dairy_____ Age at wheat_____
Did you consume a lot of candy/ sugar as a child?_____

DENTAL HISTORY

- ☐ Silver Mercury Fillings

How many?_____

- ☐ Gold Fillings
- ☐ Root Canals

How many?_____

- ☐ Implants
- ☐ Tooth Pain
- ☐ Bleeding Gums
- ☐ Gingivitis
- ☐ Problems with Chewing

Do you floss regularly (yes or no)_____

MEDICATIONS

CURRENT MEDICATIONS

Medication:	Dose:	Frequency:	Start Date:mm/yyyy	Reason for use:

PREVIOUS MEDICATIONS (LAST 10 YEARS)

Medication:	Dose:	Frequency:	Start Date: mm/yyyy	Reason for use:

NUTRITIONAL SUPPLEMENTS
(VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement and Brand:	Dose:	Frequency:	Start Date: mm/yyyy	Reason for use:

Have your medications or supplements ever caused you unusual side effects or problems? (if yes please describe)_____

_____

_____

Have you had prolonged or regular use of NASIDS (Advil, Aleve, etc.)?

_____

Have you had prolonged or regular use of Tylenol?_____

Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.)? _____

Frequent antibiotics (>3 times / year)_____

Long term antibiotics_____

Use of steroids (Prednisolone, nasal allergy inhalers)_____

Use of oral contraceptives?_____

FAMILY HISTORY

Mom:

Age_____

- ☐ Cancers (if so what type?)_____

_____

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Inflammatory Bowel Disease
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Lupus
- ☐ IBS
- ☐ Celiac Disease
- ☐ Asthma
- ☐ Eczema / Psoriasis

- ☐ Food Allergies / Sensitivities / Intolerances
- ☐ Environmental Sensitivities
- ☐ Dementia
- ☐ Parkinson's
- ☐ ALS
- ☐ Genetic Disorders
- ☐ Substance Abuse
- ☐ Psychiatric Disorders
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADHD
- ☐ Autism
- ☐ Bipolar Disease

Other:_____

Dad:

Age_____

- ☐ Cancers (if so what type?)_____

_____

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Inflammatory Bowel Disease
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Lupus
- ☐ IBS
- ☐ Celiac Disease
- ☐ Asthma
- ☐ Eczema / Psoriasis
- ☐ Food Allergies / Sensitivities / Intolerances

- ☐ Environmental Sensitivities
- ☐ Dementia
- ☐ Parkinson's
- ☐ ALS
- ☐ Genetic Disorders
- ☐ Substance Abuse
- ☐ Psychiatric Disorders
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADHD
- ☐ Autism
- ☐ Bipolar Disease

Other:_____

Brother

Age_____

- ☐ Cancers (if so what type?)_____

_____

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Inflammatory Bowel Disease
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Lupus
- ☐ IBS
- ☐ Celiac Disease
- ☐ Asthma
- ☐ Eczema / Psoriasis
- ☐ Food Allergies / Sensitivities / Intolerances
- ☐ Environmental Sensitivities

- ☐ Dementia
- ☐ Parkinson's
- ☐ ALS
- ☐ Genetic Disorders
- ☐ Substance Abuse
- ☐ Psychiatric Disorders
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADHD
- ☐ Autism
- ☐ Bipolar Disease

Other:_____

Sister:
Age_____

- ☐ Cancers (if so what type?)_____

_____

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Inflammatory Bowel Disease
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Lupus
- ☐ IBS
- ☐ Celiac Disease
- ☐ Asthma
- ☐ Eczema / Psoriasis
- ☐ Food Allergies / Sensitivities / Intolerances
- ☐ Environmental Sensitivities
- ☐ Dementia

- ☐ Parkinson’s
- ☐ ALS
- ☐ Genetic Disorders
- ☐ Substance Abuse
- ☐ Psychiatric Disorders
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADHD
- ☐ Autism
- ☐ Bipolar Disease

Other:_____

Children:

Age_____

- ☐ Cancers (if so what type?)_____
_____
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Inflammatory Bowel Disease
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Lupus
- ☐ IBS
- ☐ Celiac Disease
- ☐ Asthma
- ☐ Eczema / Psoriasis
- ☐ Food Allergies / Sensitivities / Intolerances
- ☐ Environmental Sensitivities
- ☐ Dementia
- ☐ Parkinson’s

- ☐ ALS
- ☐ Genetic Disorders
- ☐ Substance Abuse
- ☐ Psychiatric Disorders
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADHD
- ☐ Autism
- ☐ Bipolar Disease

Other:_____

Grandma:

Age_____

- ☐ Cancers (if so what type?)_____
_____
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Inflammatory Bowel Disease
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Lupus
- ☐ IBS
- ☐ Celiac Disease
- ☐ Asthma
- ☐ Eczema / Psoriasis
- ☐ Food Allergies / Sensitivities / Intolerances
- ☐ Environmental Sensitivities
- ☐ Dementia
- ☐ Parkinson’s
- ☐ ALS

- ☐ Genetic Disorders
- ☐ Substance Abuse
- ☐ Psychiatric Disorders
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADHD
- ☐ Autism
- ☐ Bipolar Disease

Other:_____

Grandpa:

Age_____

- ☐ Cancers (if so what type?)_____
_____
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Inflammatory Bowel Disease
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Lupus
- ☐ IBS
- ☐ Celiac Disease
- ☐ Asthma
- ☐ Eczema / Psoriasis
- ☐ Food Allergies / Sensitivities / Intolerances
- ☐ Environmental Sensitivities
- ☐ Dementia
- ☐ Parkinson’s
- ☐ ALS
- ☐ Genetic Disorders

- ☐ Substance Abuse
- ☐ Psychiatric Disorders
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADHD
- ☐ Autism
- ☐ Bipolar Disease

Other:_____

Aunts:
Age_____

- ☐ Cancers (if so what type?)_____
_____
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Inflammatory Bowel Disease
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Lupus
- ☐ IBS
- ☐ Celiac Disease
- ☐ Asthma
- ☐ Eczema / Psoriasis
- ☐ Food Allergies / Sensitivities / Intolerances
- ☐ Environmental Sensitivities
- ☐ Dementia
- ☐ Parkinson’s
- ☐ ALS
- ☐ Genetic Disorders
- ☐ Substance Abuse

- ☐ Psychiatric Disorders
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADHD
- ☐ Autism
- ☐ Bipolar Disease

Other:_____

Uncles:
Age_____

- ☐ Cancers (if so what type?)_____

_____

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Inflammatory Bowel Disease
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Lupus
- ☐ IBS
- ☐ Celiac Disease
- ☐ Asthma
- ☐ Eczema / Psoriasis
- ☐ Food Allergies / Sensitivities / Intolerances
- ☐ Environmental Sensitivities
- ☐ Dementia
- ☐ Parkinson’s
- ☐ ALS
- ☐ Genetic Disorders
- ☐ Substance Abuse
- ☐ Psychiatric Disorders

- ☐ Schizophrenia
- ☐ Depression
- ☐ ADHD
- ☐ Autism
- ☐ Bipolar Disease

Other:_____

SOCIAL HISTORY

Have you ever had a nutrition consultation?_____
Have you made any changes in your eating habits because of your health?_____
Describe_____
_____
_____
Do you currently follow a special diet or nutritional program?_____

Check all that apply:

- ☐ Low fat
- ☐ Low carbohydrates
- ☐ High Protein
- ☐ Low Sodium
- ☐ Diabetic
- ☐ No Dairy
- ☐ No Wheat
- ☐ Gluten Restricted
- ☐ Vegetarian
- ☐ Vegan
- ☐ Specific Program for Weight Loss / Maintenance

Type:_____

- ☐ Other_____

Height_____ Current Weight_____lbs
Usual Weight Range_____
Desired Weight Range(+/- 5lbs) _____

Highest Adult Weight_____
Lowest Adult Weight_____
Weight Fluctuations_____
How often do you weigh yourself?_____
Have you ever had your metabolism checked?_____
If yes, what was it?_____
Do you avoid any particular foods?_____
If you avoid any particular foods, what are they and why?_____

_____

_____

If you could only eat a few foods a week, what would they be?_____

_____

_____

Do you shop at the grocery store?_____
If you do not shop, who does?_____
Do you read food labels?_____
Do you cook?_____ If no, who does the cooking?_____
How many meals do you eat per week?_____

Check All Of The Factors That Apply To Your Current Lifestyle And Eating Habits

- ☐ Fast Eater
- ☐ Erratic Eating Pattern
- ☐ Eat Too Much
- ☐ Late Night Eating
- ☐ Dislike Healthy Food
- ☐ Time Constraints
- ☐ Eat More Than 50% Meals Away From Home
- ☐ Travel Frequently
- ☐ Non-Availability Of Healthy Foods
- ☐ DO Not Plan Meals Or Menus
- ☐ Reliance On Convenience Items

- ☐ Poor Snack Choices
- ☐ Significant Other Or Family Members Don't Like Healthy Foods
- ☐ Significant Other Or Family Members Have Special Dietary Needs Or Food Preferences
- ☐ Love To Eat
- ☐ Eat Because I Have To
- ☐ Have A Negative Relationship With Food
- ☐ Struggling With Eating Issues
- ☐ Emotional Eater (sad, lonely, depressed, bored)
- ☐ Eat Too Much Under Stress
- ☐ Eat Too Little Under Stress
- ☐ Don't Care To Cook
- ☐ Eating In The Middle Of The Night
- ☐ Confused About Nutrition Advice

Most important thing I should change about my diet to improve my health is . . .

_____

_____

_____

SMOKING

Currently smoking? (yes or no)_____

How many years?_____Packs per day?_____

Attempts to quit?_____

Previous smoker?(yes or no)_____

How many years?_____ Packs per day?_____

Second hand smoke exposure?_____

ALCOHOL INTAKE

How many drinks (currently) per week?_____

Previous alcohol intake (if yes, mild, moderate, or high)?_____

Have you ever been told to cut down your alcohol intake?_____

Do you ever get annoyed when people ask you about your drinking?_____
Do you ever feel guilty about your alcohol consumption?_____
Do you ever take an eye opener (morning hangover drink)?_____
Do you notice a tolerance to alcohol?_____
Have you ever been unable to remember what you did during a drinking episode?_____
Do you get into arguments or physical fights when you have been drinking?_____
Have you ever been arrested or hospitalized because of drinking?_____
Have you ever thought about getting help to control or stop your drinking?_____

OTHER SUBSTANCES

Caffeine intake?_____
If yes, what do you drink, and how much?_____
_____
Are you currently using any recreational drugs?_____
If yes, what type?_____
Have you ever used IV or inhaler recreational drugs?_____

EXERCISE

CURRENT EXERCISE PROGRAM

ACTIVITY:	TYPE:	FREQUENCY:	DURATION:
Stretching:			
Cardio/Aerobics:			

Strength:			
Other (yoga,pilates,etc):			
Sports:			
Leisure Activities:			

Rate your level of motivation for including exercise in your life (low, medium, or high)?_____
List problems that limit activity?

_____

_____

_____
Do you feel unusually fatigued?_____
If yes, describe

_____

_____

_____
Do you usually sweat when exercising?_____

PSYCHOSOCIAL

Do you ever feel significantly less vital than you did a year ago?_____
Are you happy?_____
Do you feel life has a meaning and purpose?_____
Do you believe that stress is presently reducing the quality of your life?

_____
Do you like the work you do?_____
Have you ever experienced major loss in your life?_____
Do you spend the majority of your time and money to fulfill responsibilities and obligations?_____

Would you describe your experience as a child in your family as happy and secure?_____

STRESS AND COPING

Have you ever sought counseling?_____
Are you currently in therapy?_____
If yes, describe

_____

_____

_____
Do you feel you have an excessive amount of stress in your life?_____
Do you feel you can handle the stress in your life?_____

DAILY STRESSORS: Rate on a scale of 1-10
Work_____Family_____ Finanes_____ Health_____ Other_____
Describe
other:_____
Do you practice meditation or relaxation techniques?_____
If yes, how often (daily, once a week, twice a week, etc)

_____

Check all that apply:

- ☐ Yoga
- ☐ Meditation
- ☐ Imagery
- ☐ Breathing
- ☐ Tai Chi
- ☐ Prayer
- ☐ Other:_____

Have you ever been abused, a victim of a crime, or experience significant trauma?_____

SLEEP / REST

Average number of hours of sleep you get per night?_____hours
Do you have trouble falling asleep?_____
Do you feel rested upon awakening?_____
Do you have problems with insomnia?_____
Do you snore?_____
Do you use sleeping aids?_____
If yes, what do you use?

_____

ROLES / RELATIONSHIPS

Marital status (please X on line below):
Single____ Married_____ Divorced_____ Widow_____

List Children:

Child's Name:	Age:	Gender:

Who is living in the household (number)?_____

Names:

_____

_____

_____

Their employment / occupation?

_____

_____

_____

Resources for employment support

Check all that apply

- ☐ Spouse
- ☐ Family
- ☐ Friends
- ☐ Religious / Spiritual
- ☐ Pets
- ☐ Other:_____

Are you satisfied with your sex life?_____

How well have things been going for you?

	Very Well:	Fine:	Poorly:	Does Not Apply:
Overall:				
At School:				

In Your Job:				
Social Life:				
Friends:				
Sex:				
Attitude:				
Boyfriend/ Girlfriend				
Children:				
Parents:				
Spouse:				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have any known adverse food reactions or sensitivities?

_____

If yes, describe symptoms

_____

_____

_____

Do you have any food allergies or sensitivities?

_____

If yes, list all

_____

_____

_____

Do you have any adverse reactions to caffeine?_____

When you drink caffeine do you feel:

Irritable or wired_____ Aches and pains_____ None_____

Do you adversely react to (Check all that apply):

- ☐ Monosodium Glutamate (MSG)
- ☐ Aspartame (Nutrasweet)
- ☐ Caffeine
- ☐ Bananas
- ☐ Garlic
- ☐ Onion
- ☐ Cheese
- ☐ Citrus Fruits
- ☐ Chocolate
- ☐ Alcohol
- ☐ Red Wine
- ☐ Sulfite Containing Foods (wine, dried fruit, salad bars)
- ☐ Preservatives (sodium benzoate)
- ☐ Other:_____

Which of these significantly affects you?

Check all that apply

- ☐ Cigarette Smoke
- ☐ Perfumes / Colognes
- ☐ Auto Exhaust Fumes
- ☐ Other:_____

In your work or home environment, are you exposed to:

Check all that apply

- ☐ Chemicals
- ☐ Electromagnetic Radiation
- ☐ Mold

Have you ever turned yellow (jaundiced):_____

Have you ever been told you have Gilbert's syndrome or liver disorder?_____

Explain:

_____

_____

_____

Do you have known history of significant exposure to any harmful chemicals such as the following:

Check all that apply

- ☐ Herbicides
- ☐ Insecticides (frequent visits of exterminators)
- ☐ Pesticides
- ☐ Heavy Metals
- ☐ Other (chemical name and length of exposure)

  _____

Do you dry clean your clothes frequently?_____

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures?_____

Do you have any pets or farm animals?_____

If yes, please list all

_____

_____

ANY ADDITIONAL NOTES OR COMMENTS