Nutrition Intake Form

Name ____ Age__________
Last First MI

Address____
Street City State Zip Code

Phone________________________________ E-mail__________________________________

Birth date____________________ Gender ☐ M ☐ F Occupation ______________________

Primary medical doctor ____
name office

Person to contact in case of emergency: ____________________________________
name phone

Whom may we thank for referring you to Advanced Spinal Fitness? ____________________

Reason for Visit

Please provide information on your current reason(s) for seeking nutritional counseling:

Issue	Makes it worse	Makes it better	Began/Diagnosed

Have you seen anyone else for these issues? If so, who? ______________________

What was their treatment for you?____

What do you hope to accomplish with nutritional counseling?

____

____

Personal History

Allergies (food, seasonal, environmental, etc.)

____

____

Have you ever been hospitalized? Have you ever sustained any major trauma and/or surgery?

____

____

Please check the boxes of anything you have currently, or have previously experienced:

musculoskeletal	neurological	gastrointestinal	skin
☐ arthritis	☐ muscle weakness	☐ constipation	☐ dryness
☐ bursitis	☐ numbness	☐ diarrhea/loose stool	☐ easy bruising
☐ neck pain	☐ seizures	☐ blood in stool	☐ rash
☐ back pain	☐ head trauma	☐ indigestion	☐ skin lesions
☐ sciatica	☐ stroke	☐ heartburn	☐ mole changes
☐ fracture	☐ sense changes	☐ painful swallowing	☐ acne/excessive pimples
☐dislocation	☐ headache	☐ colitis	☐ chicken pox
☐ herniated disc		☐ celiac disease	☐ tattoos
		☐ abdominal cramping	
		☐ appendicitis	

respiratory	endocrine	psychological	cardiovascular
☐ asthma	☐ diabetes	☐ memory loss	☐ high blood pressure
☐ difficulty breathing	☐ hypo/hyperthyroid	☐ depression	☐ bleeding disorder
☐ bronchitis	☐ gall bladder problems	☐ eating disorder	☐ chest pain
☐ pneumonia	☐ pancreatitis	☐ alcoholism	☐ abnormal heartbeat
☐ emphysema		☐ anxiety/nervousness	☐ poor circulation
☐chronic cough		☐ excessive stress	☐ heart attack
☐ sleep apnea			☐ low blood pressure
			☐ high cholesterol

constitutional	genitourinary	reproductive (m & f)	miscellaneous
☐ fatigue	☐ painful urination	☐ menstrual cramps	☐ cancer/tumors
☐ nausea	☐ frequent urination	☐ irregular cycle	☐ anemia
☐ excessive sweating	☐ kidney/bladder stones	☐ vaginal infections	☐ illicit drug use
☐ insomnia	☐ urinary tract infection	☐peri-/menopause	☐ tonsil removal
☐ weight changes	☐ kidney infection	☐ pelvic pain	☐ vision correction
	☐ kidney disease	☐ sexual dysfunction	☐ hearing aid
	☐ incontinence	☐ venereal disease	☐ surgery
		☐ prostate issues	

Are there any other issues or conditions not listed that you have currently, or have previously had:

____

____

Current Medications: Dosage: Duration of Use:

____

____

____

____

____

____

Do you often experience any stomach or gut pain? ☐ yes ☐ no

Do you have at least 1-2 bowel movements per day? ☐ yes ☐ no

Do you always feel tired? ☐ yes ☐ no

Do you often feel anxious or nervous? ☐ yes ☐ no

Do you experience regular headaches or migraines? ☐ yes ☐ no

Family History

Please check any of the following if applicable:

Condition	Family member afflicted
☐ cancer	
☐ heart disease	
☐ diabetes	
☐ high blood pressure	
☐ Parkinson's/Alzheimer's	
☐ autoimmune disease	
☐ thyroid problems	
☐ gall bladder problems	
☐ psychological disorders	
☐ alcoholism/drug abuse	
☐ digestive problems	
☐ other	

Lifestyle

Do you use tobacco? ☐ no ☐ yes - If yes, what kind of tobacco product do you use? ____

Do you drink alcohol? ☐ no ☐ yes - If yes, what kind of alcohol do you consume? ____
How many drinks per week? ____________

Do you consume caffeine regularly? ☐ no ☐ yes - If yes, what kind: ☐ sodas ☐ coffee ☐ tea ☐ energy drinks
How many drinks per week? _____________

Hours at work per week: __________________ Hours of sleep per night: __________________

Do you exercise or perform physical activity regularly? ☐ no ☐yes - If yes, please describe your physical activity: ________________
____

Housemates/family living with you: ____

Diet

Favorite foods: ____
Foods you dislike: ____
Foods you usually crave: ____
How often do you eat fast food/at restaurants per month? ____

Nutritional Supplements Dosage Purpose

____
____
____
____
____

Is there anything that was not asked on this form that you feel is relevant to your issues and concerns?

____
____

I hereby authorize the doctor to treat my condition, as he or she deems appropriate through use of nutritional therapy. The client also agrees that he or she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature:____ Date____________________
Guardian or Spouse's Signature Authorizing Care ____ Date____________________