Welcome to Nutritional Concepts!

This is your new client written evaluation packet. Please mail, fax, or email the following completed materials with a check payable to Nutritional Concepts or VISA/MC (you may phone in your credit card with expiration date or write it below) for $150.00.

Checklist

- ☐ Client Info Sheet
- ☐ Nutritional History & Recommendations Sheet
- ☐ List of Medications and Dietary Supplements
- ☐ Completed questionnaire
- ☐ Three day food diary
- ☐ Bloodwork (less than six months old) with blood type optional
- ☐ $150.00 check or VISA/MC ____ exp _______

Bloodwork Requirements (optional):
(most clients do through their physicians for insurance reasons)
**Please do not bring labs taken before or after a surgical procedure, if you had an infection (i.e., cold/flu), or for insurance purposes.*

CBC (including basophils and eosinophils)
CHEM SCREEN with HDL/LDL cholesterol differential
CO2 (as bicarbonate)
Thyroid
ESR (Sed Rate)
Ferritin
CRP (C-Reactive Protein)
Simple Urinalysis
Blood Type (if you do not know)
Vitamin D 25 Hydroxy [25(OH) D (optional, but recommended)]
Fasting (10PM evening prior; water OK)
No dietary supplements 24 hours prior
If on antihistamines, antibiotics or cortisone, please call our office.

If you are LOCAL and not doing through physician, our lab affiliation is Northern Illinois Clinical Labs (NICL) in Northbrook.
Cost: $169.00 or $189.00 (if you need blood type); $54 extra for vitamin D
We do not bill to insurance. Although, you will receive a receipt with diagnosis if you wish to submit.
Come to our office at Professional Plaza, 1535 Lake Cook Road, Suite 204 in Northbrook to pick up requisition and pay for lab services (the lab requires 3 business days to process bloodwork).
Our office hours are M-SAT 9AM-5PM. Directions to our office
NICL lab office hours are M-F 9:30AM-3:30PM. No appointment needed.
NICL has other lab locations.

After receiving your welcome packet, Bonnie Minsky will take 10-14 days to complete her analysis. She will then mail, fax, or email your nutritional evaluation in memo format complete with applicable materials. If you have questions, or wish to fine-tune your evaluation, we recommend waiting several

weeks and attempt to implement her suggestions before making a thirty minute in-office or phone appointment.

CLIENT INFORMATION SHEET

WELCOME TO OUR HEALTH OFFICES. NONE OF OUR SERVICES, NUTRITIONAL COUNSELING, CHIROPRACTIC AND MASSAGE THERAPY, SHOULD BE SUBSTITUTED FOR APPROPRIATE MEDICAL CONSULTATION OR TREATMENT.

OUR GOAL IS TO HAVE AVAILABLE TO YOU THE BEST, MOST QUALIFIED AND PROFESSIONAL HEALTH CARE SERVICES. WE INTEND TO REFER WHEN NECESSARY, TO EDUCATE THE COMMUNITY, AND TO EDUCATE AND WORK WITH THE ENTIRE FAMILY SO THAT EVERYONE MAY HAVE A HEALTHIER LIFESTYLE.

NAME ____ DATE______________ AGE___________
LAST FIRST

LEGAL GUARDIAN'S NAME (If you are under 18) _______________________________________

BIRTHDATE ____________________ OCCUPATION ____________________________________

ADDRESS ___________________________________ CITY ___________________ STATE ______

ZIP CODE __________ FAX _____________ CELL ____________ E-MAIL ___________________

HOME PHONE ______________ WORK PHONE ______________ CAR PHONE ______________

PHYSICIAN ____

HOW DID YOU HEAR ABOUT US? ____

LIST CURRENT HEALTH CONCERNS/SYMPTOMS:

LIST ALL SURGERIES:

LIST ALL CURRENT MEDICATIONS INCLUDING ASPIRIN:

WE EXPECT PAYMENT UPON RECEIPT OF SERVICES. PLEASE HONOR OUR 24 HOUR CANCELLATION POLICY.

NUTRITIONAL HISTORY & RECOMMENDATIONS

Client Name ____ Date (appt.) _______________

Address ____ Phone ____________________

Current Nutritional and Health Problems ____

____

PLEASE DO NOT WRITE BELOW*   *PLEASE DO NOT WRITE BELOW*   *PLEASE DO NOT WRITE BELOW

STATUS

Height ___________________ Weight __________________ Edema: Yes ____ No ____ Pallor __________________________

Complexion __________________________ Muscle Tone _______________________________ Blood Type ________________

SUSPECTED NUTRITIONAL IMBALANCES

Vitamins ____ Minerals ____

Acid/Alkaline Balance ____

Food Allergies/Sensitivities ____

Other Allergies/Sensitivities ____

Digestion: Good____ O.K.____ Needs Improvement_____ Esophagus ____

Stomach ____________________________ Intestines ___________________________ Colon ______________________________

DIETARY CONSIDERATIONS

Calories: Too many ___ Not enough ___ Recommendation for Daily Caloric Intake ____

Fiber: Good ___ Needs more ___ How much daily? ____

Fruit servings: Good ___ Not enough ___ # of servings ___ Sources ____

Vegetable servings: Good ___ Needs more ___ # of servings ___ Sources____

Protein servings: Good ___ Not enough ___ Too much ___ # of servings ____

Sources ____

Calcium: _______ mg. needed daily Sources - Dairy ___________________________Non-dairy ____________________________

Fat: Good ______ Too much ______ Not enough ______ Recommendations - _________ gm. daily ______________% of total diet

Sources ____

Sodium: Good _____ Too much _____ Not enough _____ Recommendations - _________ mg. daily

Sweeteners: Good _____ Too much _____ not enough _____ Recommendations - ______ mg. daily

Sources ____

Total Carbohydrates: Good _____ Too much _____ Not enough _____ Sources ____

Bread/Grain Carbohydrates: Good _____ Too much _____ Not enough _____

Follow-up ______________________________________ Recommendation for Other Services _________________________________

Three Day Food Diary

DAY ONE

Foods

Drinks

DAY TWO

Foods

Drinks

DAY THREE

Foods

Drinks

<u>NCI Wellness Evaluation</u>

Please complete the questionnaire to the best of your ability.
The more information we have, the better we can serve you.

<u>Information Section:</u>

First & Last Name ____ Date ___/____/______

Sex___ Weight ____ Height ____ Age____ BLOOD TYPE ____ Frame Size- S__ M__ L__

e-mail address____

Address ____

City/State/Zip Code____

Phone number _________________ Fax number __________________

<u>Part A: Lifestyle Risks*</u>
Instructions: Circle the number that best describes usage
0= Never
1= Have had in the past, but not recently
2= occasionally (1 x weekly or less)
3= regularly (2-4 x weekly)
4= daily (5-7 x weekly)
**Leave blank any items that you choose not to answer.*

Section 1: Medication/Drug Consumption

1.	Antacids	0	1	2	3	4
	specify ______________________					
2.	Antibiotics/Antifungals	0	1	2	3	4
3.	Antidepressants	0	1	2	3	4
4.	Anti-diabetic oral medication	0	1	2	3	4
5.	Insulin (injectable)	0	1	2	3	4
6.	Aspirin	0	1	2	3	4
7.	Antihistamines	0	1	2	3	4
8.	Non-aspirin (ie: Tylenol)	0	1	2	3	4
9.	Chemotherapy	0	1	2	3	4
10.	Radiation	0	1	2	3	4
11.	Cortisone	0	1	2	3	4
12.	Non steroidal anti-inflamm.	0	1	2	3	4

13.	Heart medication	0	1	2	3	4
14.	High blood pressure meds	0	1	2	3	4
15.	Hormones	0	1	2	3	4
	specify ______________________					
16.	Oral contraceptives	0	1	2	3	4
17.	Laxatives	0	1	2	3	4
18.	Muscle Relaxant	0	1	2	3	4
19.	Sleeping pills	0	1	2	3	4
20.	Diuretics	0	1	2	3	4
21.	Thyroid medication	0	1	2	3	4
22.	Ulcer medication	0	1	2	3	4
	specify ______________________					
23.	Recreational Drugs	0	1	2	3	4
24.	Other	0	1	2	3	4
	specify ______________________					

Section 2: Food/Drink Habits

1.	Alcohol (wine/beer)	0	1	2	3	4
	specify # of drinks __________					
2.	Alcohol (hard liquor)	0	1	2	3	4
	specify # of drinks __________					
3.	Coffee	0	1	2	3	4
	specify # of cups ____________					
	decaf ____ regular ____					
4.	Milk	0	1	2	3	4
	specify # of 8oz. glasses __________					
	skim ____ lowfat ____ regular ____					
5.	Vegetables	0	1	2	3	4
	specify # of servings ____________					
6.	Fruit	0	1	2	3	4
	specify # of servings ____________					
7.	Fruit juice	0	1	2	3	4
	specify # of servings ____________					
8.	Red meat	0	1	2	3	4
	specify # of 2oz. servings ____________					
9.	Fish	0	1	2	3	4
	specify # of 3oz. servings ____________					
	specify types of fish ____					
10.	Bread (including bagels, rolls)	0	1	2	3	4
	specify # of servings ____________					
11.	Poultry	0	1	2	3	4
	specify # of 2oz. servings ____________					
12.	Soft Drinks	0	1	2	3	4
	specify # of 12oz. glasses ____________ Regular ______ Diet ____					
13.	Tea	0	1	2	3	4
	specify # of 8oz. cups _____ decaf ____ regular ___					

14.	Water	0	1	2	3	4
	specify # of 8oz. glasses ____	distilled ____ mineral (bottled) ____				
		tap (unfiltered) ____ tap (filtered) ____				
15.	Hard Candy	0	1	2	3	4
16.	High sugar foods	0	1	2	3	4
	(cakes, cookies, pies, added sugar, etc.)					
17.	Non caloric sweeteners	0	1	2	3	4
	Aspartame (Nutrasweet)____	Sucralose (Splenda)____				
	Saccharin (Sweet & Low)____	Other (please specify)____________				
18.	Luncheon meats	0	1	2	3	4
	(i.e.bologna, salami, smoked meats, hot dogs)					
19.	Salty foods or added salt to prepared foods w/o tasting first	0	1	2	3	4
20.	Fried foods	0	1	2	3	4
21.	"Fast Foods"	0	1	2	3	4
	(Wendy's, McDonald's, Burger King, etc.)					
22.	Chocolate	0	1	2	3	4
23.	Margarine/Butter Substitute	0	1	2	3	4
	__ with transfat __ no transfat					
24.	Butter	0	1	2	3	4

Section 3: Lifestyle Habits/Environmental Exposure

25.	Chewing Tobacco	0	1	2	3	4
26.	Cigarettes	0	1	2	3	4
27.	Cigars	0	1	2	3	4
28.	Exposure to 2nd hand smoke	0	1	2	3	4
29.	Food Chemicals (preservatives, artificial colors/flavors, MSG)	0	1	2	3	4
30.	Dieting to lose weight	0	1	2	3	4
31.	Exercise	0	1	2	3	4
32.	If you exercise 5-7x weekly	0	1	2	3	4
	(0=15 min or less; 1=20-30min; 2=35-60min; 3=65-90min; 4=90+min)					
33.	Exposure to excess stress	0	1	2	3	4
34.	Home Water Filtration	Bath __ yes __ no				
		Drink __ yes __ no				
35.	Cosmetics use	Natural __	Regular ___			
36.	Bath & Body product use	Natural __	Regular ___			
37.	Household product use	Natural __	Regular ___			
38.	Insecticide use	Natural __	Regular ___			
39.	Lawn Care Chemical use	Natural __	Regular ___			
40.	Dry Cleaned Clothing	Natural __	Regular ___			
41.	Is your home mold-free?	__ yes __ no	__ not sure			
42.	Live 100ft. or < from power lines?	__ yes __ no	__ not sure			
43.	Do you grill more than 1x weekly?	__ yes __ no				
44.	Do you use air fresheners?	__ yes __ no				
45.	Cell phone use	___ minutes/day OR ___ hours/day				
46.	Computer use	___ minutes/day OR ___ hours/day				

47. Give a description of your vocation/career and, if applicable, how it is harming your health and/or contributing to your symptoms:

____

____

____

Section 4: Nutritional Supplements **(PLEASE bring supplement bottles to appt.)**

Instructions- Check all items you consume on a daily basis

1.	Vitamin A	____5000-10,000 i.u.	____10,000 i.u. or greater	
2.	Beta Carotene	____10,000 i.u. or greater		
3.	Vitamin C	____500mg or less	____1000mg	____1500mg or greater
4.	Vitamin E	____100-400i.u.	____1000i.u. or greater	
5.	Vit. B-3 (Niacinamide)	____50 mg. or greater		
6.	Vitamin B-6	____50 mg. or greater		
7.	Vitamin B-12	____50 mcg. or greater		
8.	Folic Acid	____400 mcg. or greater		
9.	Vitamin D	____400i.u.	____800i.u. or greater	
10.	Calcium	____500mg. or less	____1500mg. or greater	
11.	Magnesium	____250-400mg.	____1000mg. or greater	
12.	Zinc	____15mg. or less	____60mg. or greater	
13.	Chromium	____100mcg. or less	____450mcg. or greater	
14.	Iron	____15-18mg.	____19mg. or greater	
15.	Selenium	____100mcg. or less	____500mcg. or greater	
16.	CoEnzyme Q10	____30mg. or less	____100mg. or greater	
17.	Lactobacillus Acidophilus and/or Bifidus		____________________ specify	
18.	Digestive Enzymes		____________________ specify	
19.	Omega-3 (EPA/DHA)	____Less than 1 gram	____More than 1gram	
20.	Other:	____ specify		

Part B-Family Health History Questionnaire*

Instructions: Circle the number that applies.

0= Does not apply
1= Myself
2= Mother
3= Father
4= Grandparents

**Leave blank any items that you choose not to answer.*

1.	Do you have a history of headaches?	0	1	2	3	4
2.	Do you have a history of cancer?	0	1	2	3	4
3.	Do you have a history of diabetes?	0	1	2	3	4
4.	Do you have a history of heart disease?	0	1	2	3	4
5.	Do you have a history of arthritis?	0	1	2	3	4
6.	Do you have a history of hepatitis?	0	1	2	3	4

7.	Do you have a history of depression?	0	1	2	3	4	
8.	Do you have a history of alcoholism?	0	1	2	3	4	
9.	Do you have a history of HIV?	0	1	2	3	4	
10.	Do you have a history of drug abuse?	0	1	2	3	4	
11.	Do you have a history of smoking addiction?		0	1	2	3	4
12.	Do you have a history of osteoporosis?	0	1	2	3	4	
13.	Do you have a history of dementia or alzheimer's disease	0	1	2	3	4	

<u>Part C-Health Related Symptoms*</u>

Instructions: Circle the number that most accurately describes your symptoms.
0= I don't have symptom.
1= The symptom is mild or occurs rarely.
2= The symptom is moderate or occasional.
3= The symptom is severe or often.
Leave blank any items that you choose not to answer.

1.	Watery or itchy eyes	0	1	2	3
2.	Swollen, red, or sticky eyeballs	0	1	2	3
3.	Excessive Eye debris	0	1	2	3
4.	Itchy ears	0	1	2	3
5.	Fluid in ears	0	1	2	3
6.	Frequent ear infections	0	1	2	3
7.	Ringing in ears	0	1	2	3
8.	Hearing loss	0	1	2	3
9.	Need to clear throat	0	1	2	3
10.	Mucus in throat	0	1	2	3
11.	Hoarseness	0	1	2	3
12.	Irritated or sore throat	0	1	2	3
13.	Swollen gums or lips	0	1	2	3
14.	Canker sores	0	1	2	3
15.	Coughing	0	1	2	3
16.	Stuffy nose	0	1	2	3
17.	Sinus problems	0	1	2	3
18.	Hay fever	0	1	2	3
19.	Sneezing attacks	0	1	2	3
20.	Hives or rashes	0	1	2	3
21.	Nausea	0	1	2	3

22.	Water retention	0	1	2	3
23.	Specific food cravings	0	1	2	3
24.	Pain or aches in joints	0	1	2	3
25.	Pain or aches in muscles	0	1	2	3
26.	Arthritis	0	1	2	3
27.	Stiffness	0	1	2	3
28.	Limitation in range of motion	0	1	2	3
29.	Muscle fatigue	0	1	2	3
30.	Whole body fatigue	0	1	2	3
31.	Heartburn	0	1	2	3
32.	Rapid or pounding heart	0	1	2	3
33.	Irregular or skipped heartbeat	0	1	2	3
34.	Asthma	0	1	2	3
35.	Bronchitis	0	1	2	3
36.	Shortness of breath	0	1	2	3
37.	Breathing difficulty	0	1	2	3
38.	Frequent or urgent urination	0	1	2	3
39.	Hyperactivity	0	1	2	3
40.	Attention deficit disorder	0	1	2	3
41.	Anxiety	0	1	2	3
42.	Nervousness	0	1	2	3
43.	Irritability	0	1	2	3
44.	Mood swings	0	1	2	3
45.	Headaches	0	1	2	3
46.	Faintness	0	1	2	3
47.	Insomnia	0	1	2	3
48.	Dizziness	0	1	2	3
49.	Vertigo	0	1	2	3
50.	Erratic vision (not corrected by glasses or contact lenses)	0	1	2	3
51.	Anger or aggressiveness	0	1	2	3
52.	Chest pain	0	1	2	3
53.	Binge or compulsive eating	0	1	2	3
54.	Excessive overweight	0	1	2	3
55.	Extremely underweight	0	1	2	3
56.	Apathy, lethargy	0	1	2	3

57.	Poor memory	0	1	2	3	
58.	Poor concentration	0	1	2	3	
59.	Poor coordination	0	1	2	3	
60.	Difficulty in making decisions	0	1	2	3	
61.	Slurred speech	0	1	2	3	
62.	Stuttering or stammering	0	1	2	3	
63.	Depression for no apparent reason	0	1	2	3	
64.	Flushes or hot flashes	0	1	2	3	
65.	Acne	0	1	2	3	
66.	Hair loss		0	1	2	3
67.	Excessive sweating	0	1	2	3	
68.	Frequent colds or flu	0	1	2	3	
69.	Surgery of any kind in last 6 months	0	1	2	3	
70.	Enlarged prostate	0	1	2	3	
71.	Alcohol binges or being drunk	0	1	2	3	
72.	Dark circles or bags under eyes	0	1	2	3	
73.	Yellow or Grey skin	0	1	2	3	
74.	Genital itch or discharge	0	1	2	3	
75.	Food poisoning (includes salmonella shigella, giardia, e coli)	0	1	2	3	
76.	Diarrhea		0	1	2	3
77.	Constipation	0	1	2	3	
78.	Belching	0	1	2	3	
79.	Gas or bloating	0	1	2	3	
80.	Abdominal or Intestinal discomfort from 1- 4 hours after eating	0	1	2	3	
81.	Iron deficiency anemia	0	1	2	3	
82.	Very pale skin with dark circles or or sunken eyes	0	1	2	3	
83.	Digestive disorders	0	1	2	3	
84.	Craving for unusual foods or non-food items	0	1	2	3	
85.	Fatigue, apathy, or lethargy with poor concentration or comprehension	0	1	2	3	

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