Welcome to
Nutritional Concepts __________!

Your Appointment is ____________________________ @ ____________

Please bring to your 90 minute appointment with Bonnie:

- ☐ Medications and Dietary Supplements
- ☐ Completed questionnaire
- ☐ Three day lifestyle diary
- ☐ Bloodwork (less than six to eight months old) with blood type
- ☐ Optional: Prescription from your physician with diagnosis code(s). See details below.

Payment is expected upon receipt of service. We do not bill to insurance. *However, we recommend bringing a prescription (on an Rx) from your physician with diagnosis code(s). We put the diagnosis on a Superbill for you to submit. Medicare also covers medical nutrition therapy for diabetes, renal disease, obesity, and well visits with a doctor's Rx. While we cannot guarantee that our services will be covered, this protocol gives you the best chance.*

Bloodwork Requirements:
*Most clients go through their physicians for convenience with submitting to insurance.
*We do not accept labs taken before or after a surgical procedure, if you had an infection, or for life insurance.

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
Please fasting from 10PM the evening prior to the test. Water is okay. Do not take dietary supplements 24 hours prior. If taking antihistamines, antibiotics or oral cortisone, please call our office.

If not through your physician, our lab affiliation is Northern Illinois Clinical Labs (NICL) in Northbrook.
*Cost: $223.00 or $243.00 (if you need blood type)
*We do not bill to insurance. However, we will give you a receipt with diagnosis to submit to insurance.

Come to our office at Professional Plaza, 1535 Lake Cook Road, Suite 204 in Northbrook to pick up a requisition and pay for lab services (the lab requires 3 business days to process bloodwork). Our office hours are M-SAT 9AM-5PM. NICL lab office hours are M-F 8:00AM-3:30PM. No appointment needed. NICL has other lab locations.
Directions to our office:
GPS does not always provide accurate directions to our office. If you need clarification, call 847-498-3422.
Cancellation Policy:

**Please honor our 24 hour notice policy. If you are unable to keep your scheduled appointment, please give us time to fill your spot. Unless there is an illness or emergency, we will charge you half the appointment fee.*

**Many of our patients are chemically sensitive, so please refrain from wearing scented products.*

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 __________ MOBILE ________________ E-MAIL ______________________________

HOME PHONE ______________ WORK PHONE ______________ FACSIMILE _______________

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 ___________ Blood Type______

Complexion ____ Muscle Tone ____

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 ______________# servings daily

% of total diet ________ Sources ____

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

Non-caloric Sweeteners: _____Equal _____Saccharin _____ Splenda _____ Stevia _____ # servings daily

Sweeteners: Good _____ Too much _____ not enough _____ Sources ____

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

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

Food Plan ___ Follow-up ______________________ Recommendation for Other Services_______________________________________

Three Day Lifestyle Diary
(or typical patterns)

DAY ONE

Foods

Drinks

Physical Activity

Hours Slept

DAY TWO

Foods

Drinks

Physical Activity

Hours Slept

DAY THREE

Foods

Drinks

Physical Activity

Hours Slept

NCI Wellness Evaluation

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

Information Section:

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 __________________

Part A: Lifestyle Risks*

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" (Wendy's, McDonald's, Burger King, etc.)	0	1	2	3	4
22.	Chocolate	0	1	2	3	4
23.	Margarine/Butter Substitute __ with transfat __ no transfat	0	1	2	3	4
24.	Butter	0	1	2	3	4

25. If you could eat as much as you want of any food, what would it be?
(specify) ____

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.	Eat Breakfast	0	1	2	3	4
32.	Eat Quickly	0	1	2	3	4
33.	Exercise	0	1	2	3	4
34.	If you exercise 5-7x weekly (0=15 min or less; 1=20-30min; 2=35-60min; 3=65-90min; 4=90+min)	0	1	2	3	4
35.	Exposure to excess stress	0	1	2	3	4

36. Sleep duration ___ less than 7 hrs/day ___ more than 9 hrs/day
37. Home Water Filtration
 Bath __ yes __ no
 Drink __ yes __ no
38. Cosmetics use Natural __ Regular ___
39. Bath & Body product use Natural __ Regular ___
40. Household product use Natural __ Regular ___
41. Insecticide use Natural __ Regular ___
42. Lawn Care Chemical use Natural __ Regular ___
43. Dry Cleaned Clothing Natural __ Regular ___
44. Is your home mold-free? __ yes __ no __ not sure
45. Live 100ft. or < from power lines? __ yes __ no __ not sure
46. Do you grill more than 1x weekly? __ yes __ no
47. Do you use air fresheners? __ yes __ no
48. Television use ___ 2 hrs/day ___ 2-4 hrs/day ___ more than 4 hrs/day
49. Cell phone use ___ minutes/day OR ___ hours/day
50. Computer use ___ minutes/day OR ___ hours/day
51. 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 1000 mg.	____More than 1000 mg.
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
14.	Do you have a history of dreaming or daydreaming about food?	0	1	2	3	4
15.	Do you have a history of eating when you are very happy or very sad?	0	1	2	3	4

Part C-Health Related Symptoms*

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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