

Welcome to Nutritional Concepts!

Please bring to your 90 minute appointment with Bonnie:

- Medications and Dietary Supplements
- Completed questionnaire
- Three day food 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 9:30AM-3:30PM. No appointment needed. NICL has other lab locations.

Directions to our office:

Go to nutritionalconcepts.com. 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.*

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 Food Diary

DAY ONE

Foods

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Drinks

_____	_____
_____	_____
_____	_____

DAY TWO

Foods

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Drinks

_____	_____
_____	_____
_____	_____

DAY THREE

Foods

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Drinks

_____	_____
_____	_____
_____	_____

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

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=15 min or less; 1=20-30min; 2=35-60min; 3=65-90min; 4=90+min)	0	1	2	3	4
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 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 |

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