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 _____ E-MAIL _____

HOME PHONE _____ WORK PHONE _____ CELL_____

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_____

NUTRITIONAL Concepts

Date: _____

Name: _____

Address: _____

Telephone Number: _____ Email: _____

Birth Date: _____ Your current height: _____ ft. _____ in. Your current weight: _____ lbs.

Do you have any health concerns or symptoms? _____

_____

For each of the following questions, please check the response that best describes your behavior:

	Yes	No	Sometimes
1) Do you skip breakfast most days?			
2) Do you drink less than two glasses of water daily?			
3) Do you drink more than two cups of coffee (regular or decaffeinated) daily?			
4) Do you drink more than four cups (regular, decaffeinated, or herbal) tea daily?			
5) Do you eat less than four servings of vegetables each day?			
6) Do you eat less than two servings of fruit each day?			
7) Do you eat red meat (including lamb, beef) more than three times each week?			
8) Do you eat more than one serving white bread (including bagels, rolls, and muffins daily?			
9) Do you drink soft drinks daily? How many regular soft drinks per day? _____ How many diet soft drinks per day? _____			
10) Do you crave sweets?			
11) Do you crave specific foods (bread, dairy products, chocolate, corn products etc.)? Which foods?			
12) Do you skip at least one meal daily? Which meal(s) do you skip? ____ Breakfast ____ Lunch ____ Dinner			
13) Do you eat at fast food restaurants more than once a week?			
14) Do you feel sleepy or is your nose stuffy after eating certain foods, especially sweets?			
15) Are you constipated more than once a month?			
16) Do you have diarrhea more than once a month?			

_____

	Yes	No	Sometimes
17) Do you have alternating constipation and diarrhea?			
18) Do you suffer from abdominal stress or indigestion often?			
19) Do you feel better directly after eating sweets?			
20) Do sweets, alcohol, or coffee make you feel worse (especially fatigued)?			
21) Are you often still hungry after eating a meal?			
22) Do you frequently feel bloated?			
23) Do you crave salty foods?			
24) Do small amounts of alcohol (such as two beers or less, six ounces of wine or one shot of hard liquor) make you feel drunk?			
25) Do you consume a high saturated fat diet (ice cream, bacon, sausage, and/or high fat cheeses) every day?			
26) Do you eat whole grain foods (brown rice, whole grain breads/cereals, buckwheat, wild rice, oats, rye, barley. etc.) less than once a day?			
27) Do you eat legumes (soy, kidney or garbanzo beans, split peas) less than once a week?			
28) Do you eat fish less than two times a week?			
29) Do you overeat at meals?			
30) Are you a picky eater?			
31) Are you overweight? _____ Underweight? _____			
32) Do you consume non-sugar substitutes?			

Which non-sugar substitutes do you use?

____ Splenda®/Sucralose (yellow)
____ Sweet and Low®/Saccharin (pink)
____ Nutrasweet®/Equal®/Aspartame (blue)
____ Stevia Extract

How much do you consume per day? _____

33) Please list all vitamins, minerals, or other dietary supplements you are currently taking (including brands):