Welcome to Nutritional Concepts

Please bring to your 90 minute appointment:

- ☐ Names of Medications (dosages) and Dietary Supplements ***If phone consult - pictures would be beneficial****
- ☐ Completed questionnaire
- ☐ Three day lifestyle and food diary
- ☐ Bloodwork (no more than eight months old) **with** blood type
- ☐ Optional: Prescription from your physician with diagnosis code(s). See details below.
- ☐ Optional: Genetics and/or Food Reaction screening results are required prior to your appointment.

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) and the words "Medical Nutrition Therapy". We put the diagnosis on a Superbill for you to submit. Medicare may cover for diabetes, renal disease, obesity, and well visits with a doctor's Rx. We cannot guarantee that our services will be covered, however.*

REQUIRED BLOOD TESTS
ABO Grouping and Rh Typing (Blood Type - if you do not already know it)
CBC (including basophils and eosinophils)
CHEM SCREEN with HDL/LDL cholesterol differential
CO2 (as bicarbonate)
ESR (Sedimentation Rate)
Ferritin
HsCRP (High-Sensitivity C-Reactive Protein)
Simple Urinalysis w/Reflex to culture
Thyroid Panel
Vitamin D 25 Hydroxy 25(OH) D

OPTIONAL BLOOD TESTS
C-Reactive Protein, Inflammation
Cortisol
Folate
GGT
HbA1C (Hemoglobin A1C)
Homocysteine
Iron
LDH (Lactate Dehydrogenase)
Magnesium
Phosphorous
Uric Acid
Vitamin B12

BLOOD WORK PREPARATION
Please fast for at least 10 hours before your blood draw. Water is encouraged, but the only beverage allowed. Stop all dietary supplements 48 hours before your blood draw. If taking antihistamines, antibiotics or oral cortisone, please wait 48 hours, 2 weeks and 4 weeks respectively to get your blood drawn unless medically necessary. **Blood work taken after a surgical procedure, when hospitalized, if you recently had an infection, or for life insurance are not encouraged because it is not an accurate depiction of your normal metabolic state.*

WHERE TO GET YOUR BLOOD DRAWN **IF USING** INSURANCE
To ensure blood work will be run through insurance, your physician must order the blood tests. Just copy the list above and give it to your physician's office.

WHERE TO GET YOUR BLOOD DRAWN **IF NOT USING** INSURANCE
**You can submit the insurance claim yourself, if desired.*

1. Our local lab affiliate is Northern Illinois Clinical Labs (NICL), located in Northbrook 10 minutes from our office. Cost: $223.00 (without blood type) or $243.00 (with blood type). Call us at 847-498-3422 or text 847-497-0902 for details.

2. Rupa Health provides on-location or at-home blood draws nationwide. Cost: $200-$350 (phlebotomy fee not included and is paid directly to the phlebotomist; from $0-$75 depending upon on-location or at-home). Call us at 847-498-3422 or text 847-497-0902 for details.

FOOD REACTION TESTING (OPTIONAL)
Call us at 847-498-3422 or text 847-497-0902 for details about how to set this up.

GENETIC TESTING INSTRUCTIONS (OPTIONAL)
Go to http://www.puregenomics.com/patient/how-to-get-started to learn how to upload your 23andMe/Ancestry raw data (saliva sample kits must be ordered at 23andme.com or ancestry.com).

Directions to our office: GPS doesn't always provide accurate directions here. Call 847-498-3422 for directions.

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.

*If coming for an in-person visit, many of our patients are chemically sensitive, so please refrain from wearing scented products.

Lifestyle & Food Diary
(typical patterns)

	FOODS	DRINKS	PHYSICAL ACTIVITY *Type and # of Minutes*
Breakfast			
Lunch			
Dinner			
Snacks			

Client Information Section:

First & Last Name _____ **Appt. Date** ___/____/_____

Sex___ **Weight** ____ **Height** ____ **Age**____ **Birth Date** __/__/____ **Frame Size- S**__ **M**__ **L**__

Address _____

City/State/Zip Code_____

Preferred Phone number _____ **Other Phone number** _____

e-mail address_____

Blood Type_____ **Physician Name**_____

How Did You Hear About Us?_____

Notes (FOR HEALTH PROFESSIONAL USE ONLY):

Medical & Health Evaluation

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

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

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.*

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 ____ mineral (bottled-sparkling) ____ mineral (bottled- still) ____
    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)____ Stevia____ Monk Fruit____
    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. Dieting to lose weight 0 1 2 3 4
23. Eat Breakfast 0 1 2 3 4
24. Eat Quickly 0 1 2 3 4
25. Food Chemicals (preservatives, artificial colors/flavors, MSG)
    0 1 2 3 4

Section 3: Lifestyle Habits/Environmental Exposure

26. Chewing Tobacco 0 1 2 3 4
27. Cigarettes 0 1 2 3 4
28. Cigars 0 1 2 3 4
29. Exposure to 2nd hand smoke 0 1 2 3 4

30. Exercise 0 1 2 3 4
    (0=none; 1=1 day weekly; 2=2 days weekly; 3=3 days weekly; 4=4 days weekly)
31. 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)
32. Exposure to excess stress 0 1 2 3 4
    (0=15 min or less; 1=20-30min; 2=35-60min; 3=65-90min; 4=90+min)
33. Sleep duration ___ less than 7 hrs/day ___ more than 9 hrs/day
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.	Television use	___ 2 hrs/day	___ 2-4 hrs/day ___ more than 4 hrs/day
46.	Cell phone use	___ minutes/day	OR ___ hours/day
47.	Computer use	___ minutes/day	OR ___ hours/day

48. 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 all supplement bottles to your appointment; if by phone, PLEASE provide pictures or manufacturer & product name)

Part B-Family Health History Questionnaire*

Instructions: Circle or highlight 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/AIDS?	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 or highlight the number that most accurately describes your symptoms.
0= I don't have the symptom.
1= The symptom is mild or occurs rarely.
2= The symptom is moderate or occasional.
3= The symptom is severe or often.

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/surgeries	0	1	2	3

If so, what kind? _____

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