mouthfull NUTRITION

Client Protocol: **INTAKE FORM**

CONFIDENTIAL

CLIENT HEALTH HISTORY

Thank you for your interest in having a nutritional analysis completed. The information collected from this questionnaire is to help evaluate the combined effects of an individual lifestyle, including diet, environmental, chemical and emotional stressors. **Please be as honest and thorough as you can. All information collected is kept private and confidential.**

PERSONAL INFORMATION

Full Name: _____

Gender: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law ☐ Other: _____

Phone: (home) _____ (cell) _____ (work) _____

E-mail: _____

Mailing Address: _____

Occupation: _____ Employer: _____

Work Environment: ☐ Office ☐ Factory ☐ Construction ☐ Retail ☐ Home Office ☐ Other: _____

How long is your daily commute? (*One way*) ☐ No commute ☐ Under 1hr ☐ 1-2hrs ☐ 3-4hrs ☐ 5+hrs

Emergency Contact: _____

Phone number: _____ E-mail: _____

Relation: ☐ Spouse ☐ Partner ☐ Parent ☐ Legal Guardian ☐ Sibling ☐ Other: _____

How did you hear about us? _____

HEALTH CONCERNS *(please list your main complaints, symptoms and/or diagnosis)*

1. _____

2. _____

3. _____

4. _____

5. _____

MEDICAL HISTORY

Please check off any health conditions that you have been diagnosed with, or are experiencing symptoms of:

- ☐ ADHD
- ☐ AIDS
- ☐ Acne
- ☐ Atherosclerosis (*hardening of arteries*)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Alzheimer's/Dementia
- ☐ Aneurysm
- ☐ Asthma
- ☐ Cancer
- ☐ Chemical Sensitivities
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Constipation
- ☐ Crohn's Disease/Colitis/IBS
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive issues
- ☐ Diarrhea
- ☐ Excessive Stress
- ☐ Eye issues
- ☐ Eczema
- ☐ Fatty Liver Disease
- ☐ Gallstones
- ☐ Gout
- ☐ Gum/Teeth issues
- ☐ Gynaecological issues
- ☐ Hair Loss
- ☐ Headaches/Migraines
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Burn/Acid Reflux
- ☐ Hearing loss/issues
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives
- ☐ HIV
- ☐ Hypoglycemia (*low blood sugar*)
- ☐ High Blood Pressure
- ☐ Immune disorders
- ☐ Injuries
- ☐ Joint pain
- ☐ Kidney issues
- ☐ Low Blood Pressure
- ☐ Male health issues
- ☐ Miscarriage
- ☐ Memory issues
- ☐ Menstrual irregularities
- ☐ Numbness/tingling
- ☐ Overweight/Obesity
- ☐ PMS
- ☐ Poor circulation
- ☐ Poor/low appetite
- ☐ Respiratory issues
- ☐ Shingles
- ☐ Sleep issues
- ☐ Stroke
- ☐ Thyroid issues
- ☐ Urinary Tract Infections
- ☐ Varicose veins

Do any of these conditions run in your family? ☐ Yes ☐ No

Condition: _____ Family Member: _____

Condition: _____ Family Member: _____

Condition: _____ Family Member: _____

Condition: _____ Family Member: _____

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No If yes, approximately when and for what reason?

Date: _____ Reason: _____

Date: _____ Reason: _____

Blood Type: ☐ A ☐ B ☐ AB ☐ O ☐ Don't know **RH factor:** ☐ + ☐ - ☐ Don't know

Do you have any food or environmental allergies? ☐ Yes ☐ No If yes, please list and/or describe:

_____

_____

Please list any **supplements** (*vitamins, minerals, probiotics and/or herbs*) that you are currently taking:

_____

_____

_____

Please list any **prescription medications** that you are currently taking and why you are taking them:

Med: _____ Reason: _____

Med: _____ Reason: _____

Med: _____ Reason: _____

Med: _____ Reason: _____

Med: _____ Reason: _____

PLEASE CHECK ALL HEALTH CARE PRACTITIONER TYPES YOU ARE CURRENTLY SEEING:

- ☐ Medical Doctor (MD)
- ☐ Naturopath (ND)
- ☐ Chiropractor
- ☐ Physical Therapist
- ☐ Physiotherapist
- ☐ Massage Therapist (RMT)
- ☐ Herbalist
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Psychotherapist
- ☐ Homeopath
- ☐ TCM Practitioner (*Traditional Chinese Medicine*)
- ☐ Ayurvedic Practitioner
- ☐ Osteopath
- ☐ Dietitian
- ☐ Counsellor
- ☐ Spiritual Counsellor
- ☐ Other: _____

Please check all vaccinations/immunizations that you have received:

☐ Hep B ☐ HPV ☐ Flu ☐ MMR ☐ DTP ☐ Polio ☐ Chicken Pox ☐ Other: _____

Do you take any of the following over-the-counter drugs?

☐ Laxative ☐ Antacid ☐ Allergy relief ☐ Pain relief ☐ Decongestant(s) ☐ Anti-diarrheal

☐ Gas relief ☐ Cold/Flu ☐ PMS relief ☐ Nausea ☐ Other: _____

Have you ever been on antibiotics? ☐ Yes ☐ No If yes, approximately when and for what reason?

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

WOMEN'S HEALTH

Please check all birth control methods you have used or are currently using:

☐ Condoms (male or female)
☐ Birth Control Pill
☐ Birth Control Shot
☐ Birth Control Patch
☐ IUD (copper)
☐ IUD (plastic)
☐ Diaphragm
☐ Natural Family Planning
☐ Vaginal ring
☐ Sponge
☐ Spermicide
☐ Abstinence
☐ Emergency contraception (*ie: Morning After Pill*)
☐ Withdrawal

Have you ever given birth? ☐ Yes ☐ No If yes, what type of birth did you have? ☐ Vaginal ☐ C-section

How many pregnancies have you had? _____ Miscarriages? _____

Approximately how old were you when you had your first period? _____ years old

Average length of your cycle? _____ days Average length of your period? _____ days

Menstrual Blood: ☐ Bright red ☐ Red/Brown ☐ Dark ☐ Clots ☐ Watery ☐ Heavy ☐ Scant

Have you ever been on Hormone Replacement Therapy? ☐ Yes ☐ No If yes, for how long? _____

Are you currently pre, peri or post Menopause? ☐ Yes ☐ No If yes, what age did menopause begin? _____

DIET & NUTRITION

Please list the approximate times that you usually eat your meals: (*Circle AM or PM*)

BREAKFAST: _____ (AM/PM) LUNCH: _____ (AM/PM) DINNER: _____(AM/PM)

Do you ever skip meals? ☐ Yes ☐ No Which meal do you usually skip? _____

How many times do you skip meals per week? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Every day

How many glasses of water do you drink per day? ☐ 1-2 ☐ 3-4 ☐ 5-8 ☐ 8+

What is the source of your drinking water? (Please check all that apply)

☐ Filtered ☐ Tap ☐ Bottled ☐ Reverse Osmosis ☐ Spring ☐ Other: _____

Please check all beverages that you consume regularly, approximately how much you consume per day & brand name:

☐ Tea	# per day: _____	Brand: _____
☐ Coffee	# per day: _____	Brand: _____
☐ Soda / Carbonated	# per day: _____	Brand: _____
☐ Fruit juice	# per day: _____	Brand: _____
☐ Milk	# per day: _____	Brand: _____
☐ Milk alternatives	# per day: _____	Brand: _____

Do you consume alcohol? ☐ Yes ☐ No How much do you drink per week? _____

What are your favourite **FRUITS?** _____

What are your favourite **VEGETABLES?** _____

What are your **LEAST** favourite foods? _____

_____

Do you eat RED MEAT? ☐ Yes ☐ No Do you eat FISH? ☐ Yes ☐ No Do you eat PORK? ☐ Yes ☐ No

What food could you not live without?(*ie: Your "Desert Island" food*) _____

Is there anything you won't eat? _____

_____

Are you currently following any specialized diets? Please check all that apply:

- ☐ Vegetarian
- ☐ Vegan
- ☐ Ketogenic
- ☐ Gluten-Free
- ☐ Sugar-Free
- ☐ Dairy-Free
- ☐ Paleo
- ☐ Mediterranean
- ☐ Candida
- ☐ FODMAP
- ☐ GAPS
- ☐ Anti-Inflammatory
- ☐ Low-Fat
- ☐ Low-Carb
- ☐ Low-Protein
- ☐ Low-Lectin
- ☐ Elimination Diet
- ☐ Other: _____

Do you eat **ORGANIC** fruits and vegetables? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

What do you wash your fruits and vegetables with? Please check all that apply:

☐ Tap water ☐ Filtered ☐ Veggie wash ☐ Vinegar ☐ Other: _____

Do you experience any Digestive difficulties ☐ Yes ☐ No Please check all that apply:

- ☐ Bloating
- ☐ Pain
- ☐ Fatigue (after eating)
- ☐ Nausea/vomiting
- ☐ Gas/burping
- ☐ Acid reflux
- ☐ Other: _____

Do you have a bowel movement everyday? ☐ Yes ☐ No How many per day (*on average*)? _____

Please check all that apply to describe your bowel movements:

- ☐ Hard
- ☐ Soft
- ☐ Loose/poorly formed
- ☐ Pebble-like
- ☐ Painful/difficult
- ☐ Undigested food particles
- ☐ Dark
- ☐ Pale
- ☐ Sink (to bottom of toilet)
- ☐ Float
- ☐ Blood in stool
- ☐ Mucous in stool
- ☐ Other: _____

LIFESTYLE

How many times per week do you **EXERCISE?** ☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Every day

How long do you typically **EXERCISE?** ☐ Under 30mins ☐ 30mins ☐ 1-2hrs ☐ 3+hrs

What type(s) of **EXERCISE?** Please check all that apply:

- ☐ Cardio/aerobics
- ☐ Dance
- ☐ Swimming
- ☐ Sports
- ☐ Yoga/pilates/barre
- ☐ Running
- ☐ Walking/hiking
- ☐ Weight lifting
- ☐ Home workout/DVD
- ☐ Biking
- ☐ Stretching
- ☐ Other: _____

Approximately how many hours of SLEEP do you typically get per night? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 8+

Do you feel rested in the morning? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

Do you consider your job **STRESSFUL?** ☐ Yes ☐ No On a scale of 1-10? (*circle*) 1 2 3 4 5 6 7 8 9 10

Do you have any STRESSFUL relationships in your life? Please check all that apply:

☐ Family ☐ Children ☐ Boss/employer/manager
☐ Spouse/partner ☐ Friends ☐ Other: _____
☐ Ex-spouse/partner ☐ Co-Workers

Do you have **PETS?** ☐ Yes ☐ No What kind(s)? _____

Do you have **SMOKE CIGARETTES?** ☐ Yes ☐ No Approx. how many per day? _____

Do you take any **RECREATIONAL DRUGS?** ☐ Yes ☐ No What kind(s)? _____

Do you use **WIFI** at home or at work? ☐ Home ☐ Work ☐ Both ☐ Neither

Do you use a **CELL PHONE?** ☐ Yes ☐ No Approx. how many hours per day? _____

Which of the following do you currently have in your home? Please check all that apply:

☐ TV ☐ Smart Meter (for Hydro) ☐ Cordless phone
☐ Desktop computer ☐ Electric blanket ☐ Cell phone
☐ Laptop computer ☐ Electric Heating pad ☐ Fluorescent lights
☐ Tablet/iPad ☐ Microwave ☐ Wireless headphones
☐ Modem ☐ Electric kettle

Approximately how many hours of TV do you watch per day? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 8+

Approx. how many hours do you spend on a computer per day? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 8+

Do you travel by **PLANE**? ☐ Yes ☐ No Approximately how many times per year? _____

When was your last trip? _____ Where did you go? _____

Where did you live growing up? Please check all that apply:

☐ City ☐ Small town ☐ Apartment/condo
☐ Suburbs ☐ Near lake/ocean ☐ Military Base
☐ Rural ☐ Detached House ☐ Other: _____
☐ Farm ☐ Semi-detached House

Please check all **DENTAL PROCEDURES** you have had:

- ☐ Filling
- ☐ Braces/retainer
- ☐ Extraction(s)
- ☐ Crown/cap
- ☐ Dentures
- ☐ Implants
- ☐ Root Canal
- ☐ Dental Bridge
- ☐ Teeth whitening
- ☐ Dental X-rays
- ☐ Filling removal
- ☐ Other: _____

Do you use **NON-STICK** pans or bake ware? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never ☐ Not sure

Do you use **ALUMINUM** pans or bake ware? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never ☐ Not sure

Do you **DRY CLEAN** your clothes? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

Please check all **PERSONAL CARE** products you use:

- ☐ Shampoo/Conditioner
- ☐ Shaving cream
- ☐ Nail polish
- ☐ Deodorant
- ☐ Body wash
- ☐ Foundation
- ☐ Antiperspirant
- ☐ Lotion/moisturizer
- ☐ Lipstick
- ☐ Perfume/cologne
- ☐ Facial cleanser
- ☐ Mascara
- ☐ Hair spray
- ☐ Anti-aging products
- ☐ Make-up removers
- ☐ Hair dye
- ☐ Teeth whitening products
- ☐ Other: _____

Are you interested in a 1 or 2 week **MEAL PLAN**? ☐ Yes ☐ No ☐ Maybe

How much time would you ideally like to spend **COOKING** per day? ☐ None ☐ 30mins ☐ 1-2hrs ☐ 3+hrs

Do you like having **LEFTOVERS**? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

Do you enjoy **FOOD PREP**? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never ☐ I don't food prep

Is there anything that could potentially interfere with following a **TREATMENT PLAN?** Please check all that apply:

- ☐ Cooking/kitchen skills
- ☐ Social life
- ☐ Willpower
- ☐ Financial reasons
- ☐ Family obligations
- ☐ Dietary restrictions
- ☐ Work commitments
- ☐ Convenience
- ☐ Other: _____

Is there anything else you would like to discuss?

_____

_____

_____

_____