1. Please enter your information.

First Name _____ Middle Name _____ Last Name _____ Date of Birth _____

Age _____

Gender
○ Female ○ Male

Marital Status
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Address _____

Email _____

Okay to email you?
○ Yes ○ No

Home Phone _____

Okay to leave message?
○ Yes ○ No

Mobile Phone _____

Okay to leave message?
○ Yes ○ No

Preferred contact method
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

2. Height: _____

Current weight: _____

Weight six months ago: _____

Weight one year ago: _____

Would you like your weight to be different? If so, what? _____

3. What is your occupation? _____

How many hours do you work per week? _____

Where do you currently live? _____

Do you have children? _____

Do you have pets? _____

4. Do you drink alcohol?
○ Yes ○ No

If yes, how much/when? _____

Do you smoke?
○ Yes ○ No

Do you drink caffeine every morning?
○ Yes ○ No

Do you have any food allergies, restrictions, or sensitivities? If yes, please list. _____

5. Do you get noticeable irritable, light-headed, or weak if you haven't eaten in a while? _____

Do you crave certain foods? If so, which food and when? _____

Do you crave any of the following?
☐ Sugar ☐ Meat Fat ☐ Chocolate ☐ Fish ☐ Alcohol ☐ Desserts ☐ Milk ☐ Bread ☐ Fried foods ☐ Other

6. Do you take any nutritional supplements or vitamins? If so, which ones? (be specific)

Which prescription and over the counter medications do you take regularly?

7. Which oils do you use/consume?
☐ Butter ☐ Peanut Oil ☐ Canola ☐ Margarine ☐ Corn Oil ☐ Sun/Safflower ☐ Olive Oil ☐ Crisco ☐ Mayonnaise ☐ Coconut Oil ☐ Vegetable Oil ☐ Flaxseed Oil ☐ Soybean Oil ☐ Other

Do you eat primarily organic foods?

8. How many bowel movements do you have a day?

Rank your skin without lotion:
○ Very Dry ○ Dry ○ Normal ○ Oily ○ Combination

How is your sleep?

How many hours do you sleep per night?

Do you wake up at night? If yes, why?

Do you wake up without an alarm?
○ Yes ○ No

Do you wake up feeling rested?
○ Yes ○ No

Do you fall asleep within 15 mins?
○ Yes ○ No

9. **Please check off any of the following that pertain to you (past or present – please mark present conditions with a P below to it)**

☐ Acne	☐ Addictions (alcohol, drugs)	☐ Anemia
☐ Anorexia	☐ Anxiety or nervousness	☐ Arthritis (Rheumatoid or Osteo)
☐ Bladder infections (Cystitis)	☐ Bloating, gas or indigestion	☐ Blood sugar problems
☐ Bronchitis	☐ Cancer	☐ Colds or flu (frequent)
☐ Cold sores	☐ Chronic fatigue	☐ Constipation
☐ Dandruff	☐ Depression	☐ Diabetes I (insulin dependent)
☐ Diabetes II (adult onset)	☐ Diarrhea	☐ Difficulty losing weight

☐ Difficulty gaining weight	☐ Emotional problems (instability or sensitivity)	☐ Emphysema
☐ Fainting	☐ Gall bladder problems	☐ Gout
☐ Hair loss or poor hair growth	☐ Headaches	☐ Heart disease or problems
☐ Heartburn	☐ Hemorrhoids	☐ Herpes simplex I or type II
☐ High blood pressure	☐ High cholesterol	☐ HIV
☐ Hot flashes	☐ Hypoglycemia	☐ Insomnia
☐ Intestinal problems	☐ Kidney stones	☐ Liver problems
☐ Loose stools	☐ Memory loss or confusion	☐ Nails, poor growth
☐ Panic attacks	☐ Parasites	☐ Pregnant or nursing mother
☐ Respiratory problems	☐ Ringing in ears	☐ Seizures
☐ Severe mood swings	☐ Skin conditions	☐ Stroke
☐ Suicidal tendencies	☐ Thyroid condition	☐ Ulcer
☐ Yeast infections	☐ Multiple chemical sensitivity	☐ Other

10. Any pain, stiffness , or swelling?

Other concerns and/or goals?

At what point in your life did you feel best?

Any serious illnesses/hospitalizations/injuries?

Women's Health

11. Are your periods regular? ○ Yes ○ No

How many days is your flow?

How frequent?

Painful or symptomatic? Please explain:

Reaching or approaching menopause? Please explain.

Birth control history:

Do you experience yeast infections or urinary tract infections? Please Explain:

Have you had a hysterectomy?
○ Yes ○ No

Do you experience PMS?
○ Yes ○ No

Men's Health

12. Do you experience frequency with urination or difficulty urinating?

Difficulty with erection or loss of libido?

Do you have an enlarged prostate?

13. **Family History Please list any disease, illness, or ailments in your immediate family:**

Mother:

Father:

Siblings:

Grandparents:

14. **Personal Weight Loss History**

How many diets have you been on? Which ones?

What were your results?

Do you exercise?
○ Yes ○ No

If yes, what kind of exercise and how often.

Food Information

15. **Please rate the following:**

Daily energy level:
○ Excellent ○ Good ○ Fair ○ Poor

Energy level after exercise:
○ Excellent ○ Good ○ Fair ○ Poor

Daily stress level:
○ Excellent ○ Good ○ Fair ○ Poor

Do you have a support system of family and friends?

General enjoyment of life:
○ Excellent ○ Good ○ Fair ○ Poor

16. **What foods did you eat often as a child (ie: toast, cereal, pasta, etc)? **Please be very specific in your answers, this is a key piece that will be reviewed in your consultation. You can add more rows using the button below.**

Breakfast

Lunch

Dinner

Snacks

Liquids

What is your food like these days? Please complete three days of food journaling for review. Be very specific in your details.

17. **Day 1**

Date	What time did you wake up?
Time	Breakfast
Time	Mid Morning Snack
Time	Lunch
Time	Mid Afternoon Snack
Time	Dinner

Time Evening Snack

What time did you go to sleep? Did you workout today? If so, what time so, what time and was it cardio or strength?

How many ounces of water did you consume?

18. Day 2

Date What time did you wake up?

Time Breakfast

Time Mid Morning Snack

Time Lunch

Time Mid Afternoon Snack

Time Dinner

Time Evening Snack

What time did you go to sleep? Did you workout today? If so, what time so, what time and was it cardio or strength?

How many ounces of water did you consume?

19. Day 3

Date What time did you wake up?

Time Breakfast

Time Mid Morning Snack

Time Lunch

Time Mid Afternoon Snack

Time Dinner

Time

Evening Snack

What time did you go to sleep?

Did you workout today? If so, what time so, what time and was it cardio or strength?

How many ounces of water did you consume?

20. Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?

21. Do you cook?

○ Yes ○ No

What percentage of your food is home-cooked?

Where do you get the rest from?

The most important this I should do to improve my health is:

22. Anything else you would like to share?