



PERSONAL PROFILE - NUTRITIONAL ASSESSMENT

DATE: _____

NAME: _____

ADDRESS: _____

PHONE: _____ CELL _____

PLACE OF BIRTH: _____

BIRTHDATE: _____

SEX: M F

OCCUPATION: _____

DEGREES HELD: _____

REFERRED BY: _____

HEIGHT _____

WEIGHT _____

BLOOD PRESSURE-low _____ normal _____ high _____

YOUR MAIN OBJECTIVE IN NUTRITION: _____

CHIEF COMPLAINTS:

VACCINATIONS: (please check those which you've received and approx date/yr)

MMR _____ DPT _____ HEPB _____ Pneumonia _____ Flu _____
Lymes _____ Polio _____ Malaria _____ Smallpox _____ Chicken Pox _____
Other _____

BLOOD TYPE: A _____ B _____ AB _____ O _____

CHILDHOOD OR MAJOR ILLNESSES (please note date/yr of diagnosis)

DIGESTIVE SYSTEM

Diabetes _____ Irritable Bowel _____ Ulcers _____
Hypoglycemia _____ Colitis _____ Gastroenteritis _____
Insulin Resistant _____ Crohns _____ Eating Disorder _____
Esophageal Reflux(GERD) _____ Pancreatitis _____ Other GI _____
Gastroparesis _____ Chronic Burping _____

RESPIRATORY SYSTEM

Pneumonia _____ Bronchitis _____ TB _____ Asthma _____ Sleep Apnea _____ Pulmonary Obstructive Disease _____
Other _____

GENITOURINARY

Herpes _____ HIV/AIDS _____ Chlamydia _____ Cervical Dysplasia _____ Fibrocystic Breasts _____ Kidney Disease _____
Chronic Urinary or Bladder Infections _____ Yeast Infections _____ Endometriosis _____ Infertility _____
Amenorrhea _____ Polycystic Ovary Syndrome _____ Peri or Premenopause _____ note symptoms _____
Other _____

CARDIOVASCULAR

Heart Disease _____ Hypercholesterol _____ Hypertension _____ Varicose Veins _____ Scarlet Fever _____
Rheumatic Fever _____ Arrythmia _____ Mitral Valve Prolapse _____ Other _____

NEUROLOGICAL

Lupus _____ Multiple Sclerosis _____ Other Neurological _____ Lyme _____ Depression _____ Anxiety _____
ADD/HD _____ Bipolar Disorder _____ Other Mental or Neurological Illness _____

OTHER DISEASES

Thyroid Disease _____ Hepatitis _____ Mononucleosis _____ Anemia _____ Other _____

MAJOR ACCIDENTS OR INJURIES: (year and description)

ALLERGIES:

HAVE YOU EVER BEEN TESTED FOR ALLERGIES? _____

TYPE OF TESTING: ELISA _____ ALCAT _____

CURRENT MEDICATIONS

(both prescription and non-prescription, including birth control pills and estrogen replacement therapy):

VITAMIN SUPPLEMENTS (currently taking)

HOSPITALIZATIONS: (date and description)

STRESS IS A MAJOR FACTOR IN ALTERING THE BODY'S METABOLISM. THOSE LISTED BELOW ARE KNOWN TO IMPOSE THE STRONGEST EFFECTS ON BODY CHEMISTRY. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING: (please indicate dates)

Divorce _____ Death of Immediate Family Member _____ Relocation _____ Loss of Job _____

Physical Abuse _____ Sexual Abuse _____ Felony Conviction _____ Car Accident _____

HOW DO YOU FEEL WHEN YOU WAKE UP? _____

HOW MANY HOURS OF SLEEP DO YOU AVERAGE PER NIGHT? _____

DO YOU SMOKE? _____ DID YOU SMOKE? _____ FOR HOW LONG? _____

DO YOU GET DIZZY WHEN YOU STAND UP QUICKLY? _____

WHAT IS YOUR HIGHEST ENERGY TIME OF DAY AND LOWEST? _____

DO YOU HAVE CHRONIC PAIN? IF YES WHERE? _____

HOW MANY GLASSES OF WATER DO YOU CONSUME PER DAY? _____

HOW MANY TIMES A DAY DO YOU URINATE? _____

ARE YOU AWAKENED AT NITE TO URINATE? _____

HOW FREQUENTLY DO YOU HAVE BOWEL MOVEMENTS?

ONCE A DAY _____ 2-3X A WEEK _____ LESS THAN 2X A WEEK _____

FEMALES ONLY: HOW LONG ARE YOUR PERIODS?

<3 DAYS _____ 3-5 DAYS _____ 5+ DAYS _____

HOW FREQUENT ARE YOUR PERIODS? _____

DO YOU OR HAVE YOU EVER TAKEN BIRTH CONTROL PILLS? _____ HORMONE REPLACEMENT THERAPY _____

FOR HOW LONG? _____

CURRENT EXERCISE:(please note type, frequency and duration for each exercise)

DO YOU HAVE INJURIES THAT PREVENT OR IMPAIR EXERCISE?(please list)

HOW LONG HAVE YOU EXERCISED? Less than 6 mos _____ 6mos-1year _____ 1+ years _____

WHAT DO YOU DO FOR FUN? _____

DATE OF LAST COMPLETE PHYSICAL: _____

HAS YOUR PHYSICIAN MADE ANY DIETARY RECOMMENDATIONS TO YOU? (please detail)

PRIMARY PHYSICIAN NAME AND PHONE NUMBER: _____

NUTRITION ASSESSMENT: Please keep a food diary of all foods and beverages consumed for 5 days noting quantity of food and time of day consumed. Please bring to first meeting.

Please request from your physician a copy of your bloodwork drawn within the previous 12 months, to include all lab tests done, (ie hormonal, thyroid as well as CBC). Please bring copy to first meeting for evaluation.

FAMILY HISTORY: This is important in assessing your genetic predisposition for certain diseases to be evaluated against your personal risk factors.

Major diseases	Mother -Age ____	Father-Age ____	Sibling ____M__F__	Sibling ____M__F__
Cancer/type	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Other	_____	_____	_____	_____

Major Diseases	Gmother-maternal	Gfather-maternal	Gmother-paternal	Gfather-paternal
Cancer/type	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Other	_____	_____	_____	_____

Please detail any other notable disease or health problems that runs in your family history

OFFICE USE ONLY:

BP _____	PULSE _____	BODY FAT _____
RESISTANCE _____	ZN TALLY _____	HIPS _____
WAIST _____	WEIGHT _____	PH/ORAL _____
PH URINE _____		

STRUCTURAL ISSUES/DC _____