EVOLUTION
INTEGRATIVE MEDICINE
Life in Balance

NUTRITION INTAKE FORM

GENERAL INFORMATION

Full Name : _____

Date Of Birth : _____/_____/_____ **Age** : _____

Address : _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone Number : _____ **E-Mail** : _____

Status : ☐ Single ☐ Married ☐ Divorced ☐ Other

Gender : ☐ Male ☐ Female

Occupation : _____ **Are You A Retiree ?** : ☐ Yes ☐ No

How did you hear about us? : _____

Do you have Insurance? : ☐ Yes ☐ No

EMERGENCY CONTACT DETAILS

Contact Name : _____ **Can leave medical information with them:** ☐ Yes ☐ No

Relationship : _____ **Cell Number** : _____

ACKNOWLEDGEMENTS & CONSENTS

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initial

_____ I instruct the health care practitioner to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the health care offered in this practice is based on the best available evidence.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and release on my behalf for seeking reimbursement from any involved third parties.

_____ I grant permission to be called to confirm or reschedule an appointment and to be send occasional cards, letters, emails, or health information to me as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

_____ We will bill your insurance as a courtesy to you, coverage is not final until we have received payment from your insurance company. You are responsible for what insurance does not pay.

Disclaimer: Our healthcare professionals are licensed chiropractors and clinical nutritionists, not MDs or DOs. While they are trained to diagnose and treat health conditions, their services are not a substitute for medical care provided by MDs or DOs.

Patient Signature: _____ **Date:** _____

Patient Name: _____ Date: _____

NUTRITION

PLEASE LIST YOUR TOP 3 HEALTH CONCERNS

1. _____

2. _____

3. _____

WHAT ARE YOUR MAIN NUTRITIONAL GOALS? *CHECK ALL THAT APPLY*.

- ☐ I WANT TO IMPROVE MY GENERAL HEALTH AND WELLNESS
- ☐ I'M CONCERNED ABOUT MY IMMUNE HEALTH
- ☐ I'M AN ATHETE OR COMPETITOR LOOKING TO IMPROVE MY FITNESS
- ☐ I'VE HAD WEIGHT LOSS SURGERY
- ☐ I WANT TO SLOW DOWN THE AGING PROCESS
- ☐ I HAVE A CONDITION I'D LIKE TO IMPROVE
- ☐ I WANT TO LOSE WEIGHT AND FEEL ENERGIZED

DO YOU FOLLOW ANY OF THE FOLLOWING EATING PLANS: *CHECK ALL THAT APPLY*.

- ☐ HIGH PROTEIN
- ☐ GLUTEN FREE
- ☐ INTERMITTENT FASTING
- ☐ COUNT MACRONUTRIENTS
- ☐ KETOGENIC
- ☐ PLANT BASED
- ☐ VEGETARIAN
- ☐ VEGAN
- ☐ NONE
- ☐ OTHER

DO YOU HAVE ANY ALLERGIES OR DO YOU TRY TO AVOID ANY OF THE FOLLOWING?

- ☐ FISH
- ☐ SHELLFISH
- ☐ TREE NUTS
- ☐ NIGHTSHADES
- ☐ LATEX
- ☐ MILK
- ☐ GLUTEN
- ☐ MUSHROOMS
- ☐ SOY
- ☐ BEE PRODUCTS
- ☐ RAGWEED
- ☐ PEANUTS
- ☐ NONE
- ☐ OTHER

PLEASE FILL OUT THE TABLE BELOW WITH WHAT YOU EAT FOR MEALS & SNACKS

BREAKFAST	
LUNCH	
DINNER	
SNACKS	

HOW'S YOUR FRUIT & VEGETABLE DAILY INTAKE (*FIST SIZE SERVING*)? ☐ 0-2 SERVINGS ☐ 3-6 SERVINGS ☐ MORE THAN 7

HOW MANY (*FIST-SIZE*) SERVINGS OF CALCIUM-RICH FOODS DO YOU TYPICALLY EAT IN A DAY? (I.E. *DAIRY PRODUCTS, BEANS, GREEN LEAFY VEGETABLES, BROCCOLI, ALMONDS, ETC.*) ☐ 0-2 SERVINGS ☐ 3+ SERVINGS

HOW MANY SERVINGS (*APPROXIMATELY 3oz*) OF FISH DO YOU USUALLY EAT DURING THE WEEK?

☐ 0-1 SERVINGS ☐ AT LEAST 2 SERVINGS A WEEK

HOW MANY MEALS DO YOU HAVE A DAY INCLUDING SNACKS? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

ON AVERAGE, HOW MANY ALCOHOLIC BEVERAGES DO YOU HAVE IN A WEEK? ☐ 0-1 ☐ 2-5 ☐ 6+

Patient Name: _____ Date: _____

HEALTH QUESTIONNAIRE

FEMALES ONLY:

ARE YOU PREGNANT, TRYING, OR CURRENLY BREASTFEEDING? ***CIRCLE ALL THAT APPLY*.**

PREGNANT **BREASTFEEDING** **TRYING TO BECOME PREGNANT** **NONE**

DO YOU SUFFER FROM PMS? **(BLOATING, BREAST TENDERNESS, IRRITABILITY)** ☐ Yes ☐ No ☐ Sometimes

DO YOU HAVE A CYCLE EVERY MONTH? ☐ Yes ☐ No IF NO, EXPLAIN _____

DO YOU HAVE UTERINE FIBROIDS? ☐ Yes ☐ No DO YOU HAVE ENDOMETRIOSIS? ☐ Yes ☐ No

CHECK ALL THAT APPLY TO YOUR SEXUAL HEALTH.

☐ SEXUALLY ACTIVE ☐ LOW SEX DRIVE ☐ VAGINAL DRYNESS ☐ ABNORMAL DISCHARGE ☐ OTHER:

☐ NOT SEXUALLY ACTIVE ☐ REACH ORGASM ☐ CAN'T ORGASM ☐ PAIN WITH INTERCOURSE _____

MALES ONLY:

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THESE CONDITIONS? ***CIRCLE ALL THAT APPLY.***

COLON CANCER **PROSTATE CANCER** **NEITHER**

CHECK ALL THAT APPLY TO YOUR SEXUAL HEALTH.

☐ SEXUALLY ACTIVE ☐ LOW SEX DRIVE

☐ NOT SEXUALLY ACTIVE ☐ ERECTILE DYSFUNCTION ☐ OTHER: _____

DO YOU HAVE ANY OF THE FOLLOWING SKIN ISSUES? (***CHECK ALL THAT APPLY***) ☐ ECZEMA ☐ PSORIASIS ☐ ACNE ☐ NONE

ARE YOU PRONE TO GETTING URINARY TRACT INFECTIONS (UTI)? ☐ Yes ☐ No

HAVE YOU TAKEN ANTIBIOTICS WITHIN THE LAST YEAR? ☐ Yes ☐ No

HOW OFTEN TO DO YOU FEEL SICK? ☐ HARDLY EVER ☐ 2-3 TIMES PER YEAR ☐ MORE THAN ONCE A MONTH

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS RELATED TO YOUR EYE, NOSE, & GUM HEALTH?

☐ GINGIVITIS ☐ SINUSITIS ☐ OTHER, EXPLAIN _____

DO YOU STRUGGLE WITH ANY OF THESE? ***CIRLCE ALL THAT APPLY***.

ASTHMA **FREQUENT VIRAL INFECTIONS** **MIGRAINES** **SEASONAL ALLERGIES** **PERSISTENT COLD SORES** **NONE**

HOW ARE YOUR HAIR, SKIN, & NAILS? ☐ GREAT ☐ COULD USE SOME HELP

DO YOU HAVE ANY CONDITIONS RELATED TO YOUR KIDNEY & BLADDER HEALTH?

☐ HISTORY OF KIDNEY STONES ☐ FREQUENT BLADDER INFECTIONS ☐ NONE ☐ OTHER _____

DO YOU HAVE ANY OF THESE CONDITIONS? ***CIRCLE ALL THAT APPLY*.**

CELIAC DISEASE **HASHIMOTO'S THYROIDITIS** **CHRONIC FATIGUE SYNDROME** **LUPUS** **FIBROMYALGIA** **CANCER**

DO YOU OR YOUR IMMEDIATE FAMILY MEMBERS HAVE ANY OF THE FOLLOWING CONDITIONS RELATED TO BLOOD SUGAR & ENDOCRINE HEALTH? ***CIRCLE ALL THAT APPLY*.**

DIABETIC RETINOPATHY **HIGH HbA1c/PREDIABETES** **HYPOTHYROIDISM** **DIABETIC NEUROPATHY** **TYPE I DIABETES**

TYPE II DIABETES **GENERALLY HIGH BLOOD SUGAR LEVELS** **NONE**

DO YOU OR YOUR IMMEDIATE FAMILY MEMBERS HAVE ANY OF THE FOLLOWING CONDITIONS RELATED TO HEART HEALTH? ***CIRCLE ALL THAT APPLY*.**

HIGH BLOOD PRESSURE **CONGESTIVE HEART FAILURE** **HIGH CHOLESTEROL & I *AM* TAKING STATINS** **ANGINA**

ATHEROSCLEROSIS **HIGH TRIGLYCERIDES** **HIGH CHOLESTEROL & I AM *NOT* TAKING STATINS** **NONE**

Patient Name: _____ Date: _____

HEALTH QUESTIONNAIRE CONTINUED

DO YOU GET LESS THAN 20 MINUTES OF DAILY SUN EXPOSURE? ☐ YES ☐ NO

DO YOU HAVE ANY DIGESTIVE ISSUES? ☐ IBS ☐ SIBO ☐ DIARRHEA ☐ GAS OR BLOATING ☐ HEARTBURN ☐ INDIGESTION ☐ CONSTIPATION ☐ NO COMPLAINTS ☐ OTHER PROBLEM

HOW MUCH TIME DO YOU SPEND LOOKING AT SCREENS? ☐ NOT OFTEN ☐ A FEW HOURS A DAY ☐ I'M ALWAYS ON THE COMPUTER/PHONE

DO YOU EXPERIENCE ANY OF THE FOLLOWING? ***CIRCLE ALL THAT APPLY***.

NONE **CHRONIC ACHES & PAINS** **FLUCTUATING ENERGY LEVELS THROUGHOUT THE DAY**

ON AVERAGE, HOW ARE YOUR ENERGY LEVELS? ☐ PRETTY GOOD ☐ HAVE ENERGY SLUMPS ☐ ALWAYS EXHAUSTED

HOW'S YOUR MOOD? ☐ GREAT ☐ NOT TOO BAD ☐ A BIT DOWN SOMETIMES ☐ I'M HARDLY EVER HAPPY

ARE YOU EXPERIENCING A LOT OF STRESS? ☐ YES ☐ NO

HOW DO YOU SLEEP? ☐ GREAT ☐ I DON'T GET ENOUGH SLEEP ☐ MY MIND RACES WHEN I TRY TO SLEEP ☐ HARD TIME STAYING ASLEEP ☐ I DON'T SLEEP WELL FOR ANOTHER REASON

WHICH BEST DESCRIBES YOUR FITNESS OR ACTIVITY LEVEL? ☐ I RARELY/NEVER WORKOUT ☐ I WORKOUT OFTEN ☐ I SOMETIMES WORKOUT ☐ I'M AN ATHLETE OR COMPETITOR

HOW OFTEN DO YOU DO CARDIO EACH WEEK? ☐ LESS THAN 2 HOURS ☐ 2-3 HOURS ☐ 3-4 HOURS ☐ MORE THAN 4HRS

ARE YOU TRYING TO INCREASE STRENGTH? ☐ YES ☐ NO

HOW OFTEN ARE YOU SORE FROM WORKING OUT? ☐ ONCE IN A WHILE ☐ SOMETIMES ☐ WAY TOO OFTEN

DO YOU EXPERIENCE JOINT OR TENDON PAIN? ☐ YES ☐ NO

DO YOU SMOKE? ☐ YES ☐ NO ARE YOU EXPOSED TO SECONDHAND SMOKE? ☐ YES ☐ NO

HAVE YOU HAD PROLONGED OR REGULAR USE OF NSAIDS (ADVIL, ALEVE, ETC) MOTRIN, ASPIRIN? ☐ YES ☐ NO

HAVE YOU HAD PROLONGED OR REGULAR USE OF TYLENOL? ☐ YES ☐ NO

DO YOU HAVE REGULAR EXPOSURE TO ANY OF THE FOLLOWING: ***CHECK ALL THAT APPLY.***

- ☐ MOLD
- ☐ DAMP ENVIRONMENTS
- ☐ CLEANING CHEMICALS
- ☐ STAGNANT OR STUFFY AIR
- ☐ PAINTS
- ☐ REGULAR CONTACT WITH SMOKERS
- ☐ OLD PAINT
- ☐ HEAVY METALS (LEAD, MURCURY, ETC)
- ☐ PESTICIDES
- ☐ RENOVATIONS
- ☐ HERBICIDES
- ☐ WATER LEAKS
- ☐ CARPETS OR RUGS
- ☐ AIRPLANE TRAVEL
- ☐ HARSH CHEMICALS (SOLVENTS, GLUES, ACIDS, ETC)
- ☐ ELECTROMAGNETIC RADIATION

IS THERE A HISTORY OF A SIGNIFICANT EXPOSURE TO ANY HARMFUL CHEMICALS? ☐ YES ☐ NO

IF YES: CHEMICAL NAME, LENGTH OF EXPOSURE, DATE _____

DO YOU HAVE ANY PETS OR FARM ANIMALS? ☐ YES ☐ NO IF YES, WHERE DO THEY LIVE? ☐ INSIDE ☐ OUTSIDE ☐ BOTH

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING: INCLUDING DOSAGE & FREQUENCY

_____

_____

_____