

New Heights Chiropractic & Nutrition 3331 Street Road

Two Greenwood Square, Suite 107 Bensalem, PA 19020

**Nutrition - New Client Intake Form**

All information received on this form will be treated as strictly confidential. Please fill out the form ***completely and accurately***. This information is essential to helping the nutrition therapist to develop a wellness program that addresses your needs, goals and interests and is safe and effective.

Appointment Date and Time:

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| --- |
| **Demographics** |
| FirstName |  | MiddleName |  | LastName |  |
| Date of Birth |  | Age |  | Gender | Male Female |
| Mailing Address |  |
| City, State, Zip code |  |
| Preferred phone | Home Work Mobile |
| Secondary phone | Home Work Mobile |
| Email address |  |
| Referred by |  |
| **Concerns** |
| What health and/or nutrition concerns would you like to focus on during your visit? |
| 1. |
| 2. |
| 3. |

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| **Medical History** |
| Please check “yes” for the health conditions that your doctor has diagnosed, and then record the approximate date of onset. |
| **CONDITION** | **Yes** | **Date of Onset** | **CONDITION** | **Yes** | **Date of Onset** |
| **GASTROINTESTINAL** |  |  | **INFLAMMATORY / AUTOIMMUNE** |  |  |
| Irritable Bowel Syndrome |  |  | Chronic Fatigue Syndrome |  |  |
| Inflammatory Bowel Disease |  |  | Rheumatoid Arthritis |  |  |
| Crohn’s Disease |  |  | Lupus SLE |  |  |
| Ulcerative Colitis |  |  | Frequent Infections |  |  |
| Celiac Disease |  |  | Severe Infectious Disease |  |  |
| Gastric or Peptic Ulcer Disease |  |  | Herpes |  |  |
| GERD, reflux / heartburn |  |  | Gout |  |  |
| Hepatitis C or Liver Disease |  |  | Other: |  |  |
| Food Intolerance |  |  |  |  |  |
| Other: |  |  |  |  |  |
| **RESPIRATORY** |  |  | **MUSCULOSKELETAL / PAIN** |  |  |
| Asthma |  |  | Osteoarthritis |  |  |
| Chronic Sinusitis |  |  | Chronic pain |  |  |
| Sleep Apnea |  |  | Fibromyalgia |  |  |
| Bronchitis or Emphysema |  |  | Migraines |  |  |
| Tuberculosis |  |  | Other: |  |  |
| Other: |  |  |  |  |  |
| **CARDIOVASCULAR** |  |  | **URINARY / REPRODUCTIVE** |  |  |
| Heart Disease / Heart Attack |  |  | Kidney Stones |  |  |
| Stroke |  |  | Urinary Tract Infections |  |  |
| Elevated Cholesterol |  |  | Yeast Infection |  |  |
| Irregular Heart Rate |  |  | Prostate Problem |  |  |
| High Blood Pressure |  |  | Other: |  |  |
| Other: |  |  |  |  |  |
| **NEUROLOGICAL / BRAIN** |  |  | **METABOLIC / ENDOCRINE** |  |  |
| Depression |  |  | Type 1 Diabetes |  |  |
| Anxiety |  |  | Type 2 Diabetes |  |  |
| Bipolar disorder |  |  | Metabolic syndrome |  |  |
| ADD/ADHD |  |  | Hypoglycemia |  |  |
| Multiple Sclerosis |  |  | Hypothyroidism |  |  |
| Seizures |  |  | Hyperthyroidism |  |  |
| Anorexia Nervosa |  |  | Polycystic Ovarian Syndrome |  |  |
| Bulimia |  |  | Infertility |  |  |
| Unspecified Eating Disorder |  |  | Other: |  |  |
| Parkinson’s Disease |  |  |  |  |  |
| Other: |  |  |  |  |  |
| **DERMATOLOGICAL** |  |  | **CANCER: Please list type(s) and treatments.** |  |  |
| Eczema |  |  |  |  |  |
| Psoriasis |  |  |  |  |  |
| Acne |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Additional health conditions your doctor has diagnosed: |
|  |
| Please list any previous injuries, surgeries, and hospitalizations. Provide your age and date if known. |
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| Your Birth History: Vaginal C-section | Were you breastfed as an infant? Yes No |

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| **Family History** |
| Have any of your close relatives (parent, sibling, child grandparent) been diagnosed with the following? Please check, describe, and provide age of onset for those that apply. |
| **Condition** | **Yes** | **Family Member(s)** | **Age of****Onset** | **Description** |
| Heart Disease |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Stroke |  |  |  |  |
| Diabetes |  |  |  |  |
| Cancer |  |  |  |  |
| Overweight |  |  |  |  |
| Food Intolerance |  |  |  |  |
| AutoimmuneDisease |  |  |  |  |
| **Oral History** |
| Do you visit a dentist twice per year? Yes No |
| Do you have any silver/mercury amalgam fillings? Yes No If yes, how many? |
| **Allergies** | **Allergic Symptoms Experienced** |
| Food |  |  |
| Medication |  |  |
| Supplement |  |  |
| Environmental |  |  |
| **Medications and Supplements:** Please list all prescription medications, nutritional supplements, and herbs/botanicals you are currently taking.If this information is already in the Duke Medical System, you do not need to complete this section. |
| **Medication Name** | **Year Started** | **Dose** | **Frequency** | **Reason** |
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| **Herb/Supplement** | **Year Started** | **Dose** | **Frequency** | **Reason** |
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| 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 |
| Have you had prolonged or regular use of acid-blocking drugs (Zantac, Pepcid, etc.)? Yes No |
| Have you taken antibiotics > 3 times per year? Yes No |
| Have you been on antibiotics long term (> 1 month continuously)? Yes No |

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| **Lifestyle Information** |
| Do you engage in physical activity on a regular basis? Yes No If yes, complete the table below |
| **Activity** | **Number of Days per Week** | **Duration (minutes) per Session** |
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|  |  |  |
| How many hours do you sleep on weeknights? < 6 6-8 8-10 10 + |
| How many hours do you sleep on weekends? < 6 6-8 8-10 10 + |
| Check which apply to you: Trouble falling asleep Wake up during the night Don’t feel rested |
| How do you handle stress? What helps you relax? |
| **Environmental Exposures** |
| What is your occupation? |
| Are you regularly exposed to any of the following? |
| * Cigarette smoke
* Auto exhaust / fumes
 | * Paint fumes
* Chemicals
 | * Perfumes
* Dry-cleaned clothes
 | * Nail Polish
* Hair dyes
 |
| Do you feel dizzy or get a headache when exposed to strong chemical odors or fumes? Yes No If yes, please explain. |
| Please describe any significant past or present exposure to substances such as recreational drugs, alcohol, or chemicals. |
| **Nutrition History** |
| Have you ever had an appointment with a dietitian or nutritionist? Yes No |
| Have you changed your eating habits for a health reason? Yes No Please describe. |
| Are you currently following a particular diet or nutrition plan? Yes No Please describe. |
| Do you avoid any particular foods? Yes No Please explain. |

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| **Nutrition History (continued)** |
| Do you have any adverse food reactions (intolerances or allergies)? Yes No Please explain. |
| Height: | Current Weight: | Usual Weight Range: | Desired Weight: |
| Have you recently lost or gained weight? Yes No If yes, please describe. |
| Do you have or have you had an eating disorder? Yes No If yes, please describe. |
| How many meals do you eat each day? | How many snacks do you eat each day? |
| How many meals do you buy from a restaurant or fast food **per week?** 0-1 2-3 4-6 > 6 |
| Do you drink alcohol? Yes No If yes, how many drinks **per week?** |
| Do you drink caffeinated beverages? Yes No If yes, how many cups **per day?** |
| Do you use any natural or artificial sweeteners? Yes No If yes, which ones? |
| What is your favorite meal? |
| Check all of the factors that apply to your eating habits and current lifestyle: |
| * Love to eat
* Love to cook
* Emotional eater
* Late night eater
* Struggle with eating issues
* Family members have different tastes
* Dislike cooking
 | * Fast eater
* Erratic eating patterns
* Eat too much
* Rely on convenience foods
* Eat fast food frequently
* Make poor snack choices
* Confused about food/nutrition
 | * Live alone or eat alone often
* Do not plan meals or menus
* Time constraints
* Travel frequently
* Eat only because I have to
* Negative relationship with food
* Dislike healthy food
* Don’t know how to cook
 |
| **Food Diary:** Please record what you eat and drink during one typical day (24 hour period).Please be sure to include all beverages, cream and sweetener added to beverages, and condiments added to foods. |
| Time woke up: | Bedtime: |
| Time | Food / Beverage Items | Amount(e.g. cups, oz., tsp) | Location (Home/Away) |
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| **Food Frequency Questionnaire** – How often do you eat the following? |
| **Food** | **Never or****<4x/year** | **Rarely or****<4x/month** | **Once/wk** | **2x/wk** | **3x/wk** | **Daily** |
| Cheese | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Yogurt, Kefir | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cow’s Milk | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Milk Substitute (soy, coconut, almond, rice, or hemp seed milk ) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Red Meat | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pork (pork loin, pork roast, pork chops, barbecue) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Processed Meat (sausage, bacon, lunch meat) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Chicken | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eggs | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cold Water Fish (*striped bass, wild Alaskan salmon, herring, sardines, anchovies, mackerel, Alaskan halibut, Alaskan cod)* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other fish or shellfish- Indicate type: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Beans, Legumes (black beans, kidney beans, white beans, lentils) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Whole Soy Foods (edamame, soy nuts) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tofu, Tempeh | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Soy “meat alternative” (ex. Tofurkey, soy “sausage”, soy “bacon”) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Berries | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Other Fruits**- Indicate type: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cruciferous Vegetables (cabbage, broccoli, Brussels sprouts) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Green Leafy Vegetables (e.g. spinach, kale, collards, greens) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Yellow Fruits and Vegetables (e.g. yellow peppers, corn) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other Green Fruits and Vegetables (e.g. peas, broccoli, avocado, cucumbers) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Blue/Purple Fruits and Vegetables (e.g. blueberries, prunes, beets, purple cabbage) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Red Fruits and Vegetables (e.g. cherries, apples, tomatoes, kidney beans) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Orange Fruits and Vegetables (e.g. orange, cantaloupe, carrots, sweet potato) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| White/Tan Fruits and Vegetables (e.g. onions, garlic, ginger, nuts) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Turmeric, Cumin, Ginger, Rosemary, Oregano, Parsley | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Nuts, Nut Butters-** Indicate type: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Avocado, Extra Virgin Olive Oil , Canola Oil | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vegetable oil (corn, sunflower, safflower, etc. – NOT olive oil) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Butter, ghee | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| White Rice | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| White Pasta | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| White Bread | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bagels | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| English Muffins | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pancakes or Waffles | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **Food** | **Never or****<4x/year** | **Rarely or****<4x/month** | **Once/wk** | **2x/wk** | **3x/wk** | **Daily** |
| Buttermilk Biscuits | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Chips | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pretzels | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Popcorn | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other Snack Food (crackers, Goldfish) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 100% Whole Wheat, Rye, Barley (whole wheat bread and pasta) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other Whole Grains (millet, quinoa, amaranth, flax, oats, brown rice) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ice Cream | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pastries, cookies, cakes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Juice-** Indicate type: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Punch, Lemonade, or Sweet Tea | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diet Soda | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Soda (not diet) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Red Wine | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tea ( white, green, black) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Daily Intake Summary** |
| What type(s) of protein do you consume most days of the week? (Check all that apply.)* Animal meat ☐ Beans ☐ Eggs ☐ Soy-based ☐ Dairy ☐ Nuts and seeds
 |
| How many servings of fruit do you have in a day? |  |
| How many servings of vegetables do you have in a day? |  |
| Provide an estimate of the amount of each beverage that you consume on an average day. Circle the label that is most appropriate based on how you consume the beverage. |
| Water: ounces, cup(s) Coffee: ounces, cup(s) | Diet soda: \_ cup(s), can(s), liter(s) Non-diet soda: cup(s), can(s), liter(s) | Tea: cup(s)Other: \_ |

**SYMPTOM SURVEY**

Patient Name: Date:

Completing this form is particularly helpful if you have experienced persistent and bothersome symptoms from more than one category below. Score every symptom based on your experience over the last 30 days. Start with the first symptom and ask yourself, "Lately, have I experienced this symptom?" If you answer no or almost not at all, then write a "0" in the corresponding field. If the answer is yes, then ask yourself if you experience the symptom occasionally (less than 2 times in a week) or frequently (2 or more times in a week). After you have decided on the frequency, then ask yourself if the symptom is "Severe" or "Not Severe". Using the SCALE OF SYMPTOM POINTS listed below, write the appropriate score in the corresponding field for EVERY symptom listed. Total the points for each category, and add all category totals to come up with the Grand Total.

|  |  |
| --- | --- |
| **SCALE OF SYMPTOM POINTS:**0 = Do Not Suffer From This Ever or Almost Ever1 = Suffer OCCASSIONALLY (less than 2 times per week), is not severe 2 = Suffer FREQUENTLY (2 or more times per week), is not severe3 = Suffer OCCASSIONALLY and is severe 4 = Suffer FREQUENTLY and is severe | Grand Total: |

# CONSTITUTIONAL

\_\_\_\_\_ Fatigue (sluggish, tired)

\_\_\_\_\_ Hyperactive (nervous energy)

\_\_\_\_\_ Restless (can’t relax/sit still)

\_\_\_\_\_ Sleepiness During Day

\_\_ \_ Insomnia at Night

 Malaise

\_\_ \_ TOTAL (0-20)

# EMOTIONAL/MENTAL

\_\_\_\_\_ Depression (feelings of hopelessness)

\_\_\_\_\_ Anxiety (vague fears, uneasiness)

\_\_\_\_\_ Mood Swings (rapid distinct changes)

\_\_\_\_\_ Irritability

\_\_\_\_\_ Forgetfulness

\_\_\_\_\_ Lack of concentration/focus

\_\_ \_ TOTAL (0-24)

# HEAD/EARS

\_\_\_\_\_ Headache (any kind)

 Migraine (diagnosed)

\_\_\_\_\_ Earache

\_\_\_\_\_ Ear Infection

\_\_\_\_\_ Ringing in Ear

\_\_\_\_\_ Itchy Ears

\_\_\_\_\_TOTAL (0-24)

# SKIN

\_\_\_\_\_ Blemishes, Acne

\_\_\_\_\_ Rashes, Hives

\_\_\_\_\_ Eczema

\_\_\_\_\_ “Rosy” Cheeks

\_\_\_\_\_ TOTAL (0-16)

Comments:

# NASAL/SINUS

\_\_ Post Nasal Drip

\_\_ Sinus Pain

\_\_ Runny Nose

\_\_ Stuffy Nose

\_\_ Sneezing

\_\_ TOTAL (0-20)

# MOUTH/THROAT

\_\_\_\_\_ Sore Throat

\_\_\_\_\_ Swollen Throat

\_\_\_\_\_ Swelling of Lips/Tongue

\_\_\_\_\_ Gagging/Throat Clearing

\_\_\_\_\_ Lesions ("Canker Sores")

\_\_\_\_\_ TOTAL (0-20)

# LUNGS

\_\_\_\_\_ Wheezing" (Asthma or

Asthma-like Symptoms)

\_\_\_\_\_ Chest Congestion

\_\_\_\_\_ Non-Productive Coughing

\_\_\_\_\_ Productive Coughing

\_\_\_\_\_ TOTAL (0-20)

# EYES

\_\_\_\_\_ Red or Swollen Eyes

\_\_\_\_\_ Watery Eyes

\_\_\_\_\_ Itchy Eyes

\_\_\_\_\_ Dark Circles" or "Baggy"

\_\_ \_ TOTAL (0-16)

# GENITOURINARY

\_\_\_\_\_ Increased Urinary Frequency

\_\_\_\_\_ Painful Urination

\_\_\_\_\_ TOTAL (0-8)

# MUSCULOSKELETAL

\_\_\_\_\_ Joint Pains/Aching

\_\_\_\_\_ Stiff Joints

\_\_\_\_\_ Muscle Aches

\_\_\_\_\_ Stiff Muscles

\_\_\_\_\_ TOTAL (0-20)

# CARDIOVASCULAR

\_\_\_\_\_ Irregular Heartbeat

\_\_\_\_\_ High Blood Pressure \_\_\_

TOTAL (0-8)

# DIGESTIVE

\_\_\_\_\_ Heartburn/Esoph.Reflux

\_\_\_\_\_ Stomach Pains/Cramps

\_\_\_\_\_ Intestinal Pains/Cramps

\_\_\_\_\_ Constipation

\_\_\_\_\_ Diarrhea

\_\_\_\_\_ Bloating Sensation

\_\_\_\_\_ Gas (of Any Kind)

\_ Nausea, Vomiting

\_\_\_\_\_ Painful Elimination

\_\_\_\_\_ TOTAL (0-36)

# WEIGHT MANAGEMENT

\_\_\_\_\_ **Record Actual Weight**

**\_\_\_\_\_\_ Approximate Height**

\_\_\_\_\_ Fluctuating Weight

\_\_\_\_\_ Food Cravings

\_\_\_\_\_ Water Retention

\_\_\_\_\_ Binge Eating or Drinking

\_\_\_\_\_ Purging (all methods)

\_\_\_\_\_ TOTAL (0-20)