



# Nourishing Wellness

Good health is a choice you can make today!

## Nutritional Consultation Questionnaire

### General Information

First name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (work): \_\_\_\_\_

Cell phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Marital Status: \_\_\_\_\_ How many children do you have? \_\_\_\_\_

Occupation: \_\_\_\_\_ Do you like your current career? \_\_\_\_\_

How did you hear about our services?

\_\_\_\_\_

What are your most important health concerns?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you hope to achieve in your visit with us?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Lifestyle and Nutrition History

Do you drink caffeine? ☐ Yes ☐ No Cups per day ☐ 1 ☐ 2-4 ☐ >4

Do you drink soda? ☐ Yes ☐ No 12 oz can/bottle/day ☐ 1 ☐ 2-4 ☐ >4

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10

Do you smoke? ☐ Yes ☐ No How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_  
2nd Hand Smoke Exposure? \_\_\_\_\_

Do you use recreational drugs? ☐ Yes ☐ No Type: \_\_\_\_\_ How often? \_\_\_\_\_

Do you get noticeably irritable, light headed, or weak if you haven't eaten in a while? \_\_\_\_\_

Do you crave any of the following?

<input type="checkbox"/> Sugar	<input type="checkbox"/> Meat	<input type="checkbox"/> Fat	<input type="checkbox"/> Chocolate	<input type="checkbox"/> Fish	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Desserts	<input type="checkbox"/> Milk	<input type="checkbox"/> Salt	<input type="checkbox"/> Bread	<input type="checkbox"/> Fried Foods	<input type="checkbox"/> Other _____

Which oils do you use/consume?

<input type="checkbox"/> Butter	<input type="checkbox"/> Peanut Oil	<input type="checkbox"/> Canola	<input type="checkbox"/> Margarine	<input type="checkbox"/> Corn Oil	<input type="checkbox"/> Sun/Safflower
<input type="checkbox"/> Olive Oil	<input type="checkbox"/> Crisco	<input type="checkbox"/> Mayonnaise	<input type="checkbox"/> Coconut Oil	<input type="checkbox"/> Vegetable Oil	<input type="checkbox"/> Flaxseed Oil
<input type="checkbox"/> Soybean Oil	<input type="checkbox"/> Other _____				

Do you avoid any particular foods? ☐ Yes ☐ No

If yes, types and reasons? \_\_\_\_\_

Do you overeat? ☐ Yes ☐ No If so, which foods and how often? \_\_\_\_\_

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? \_\_\_\_\_

Do you read food labels? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No If no, who does the cooking? \_\_\_\_\_

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5

Check all that apply to your current lifestyle and eating habits:

- |  |   |
|--|---|
| <input type="checkbox"/> Fast eater                                | <input type="checkbox"/> Household members don't like healthy foods                         |
| <input type="checkbox"/> Erratic eating pattern                    | <input type="checkbox"/> Household members have special dietary needs or food preferences   |
| <input type="checkbox"/> Eat too much                              | <input type="checkbox"/> Emotional eater (eat when sad, lonely, depressed, stressed, bored) |
| <input type="checkbox"/> Late night eating                         | <input type="checkbox"/> Have a negative relationship to food                               |
| <input type="checkbox"/> Dislike healthy foods                     | <input type="checkbox"/> Struggle with eating issues  |
| <input type="checkbox"/> Time constraints                          | <input type="checkbox"/> Eat too much under stress  |
| <input type="checkbox"/> Eat more than 50% of meals away from home | <input type="checkbox"/> Eat too little under stress  |
| <input type="checkbox"/> Travel frequently                         | <input type="checkbox"/> Don't care to cook   |
| <input type="checkbox"/> Don't plan meals or menus                 | <input type="checkbox"/> Eat in the middle of the night                                     |
| <input type="checkbox"/> Non-availability of healthy foods         | <input type="checkbox"/> Eat because I have to  |
| <input type="checkbox"/> Reliance on convenience items             | <input type="checkbox"/> Confused about nutrition advice                                    |
| <input type="checkbox"/> Poor snack choices                        |   |
| <input type="checkbox"/> Love to eat                               |   |

The most important thing I should change about my diet to improve my health is:

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Rank your skin without lotion:

☐ Very Dry   ☐ Dry   ☐ Normal   ☐ Oily   ☐ Combination

How much water do you drink daily? \_\_\_\_\_

How often do you have bowel movements? \_\_\_\_\_

How often do you urinate? \_\_\_\_\_

### Exercise

Do you exercise? \_\_\_\_\_

If so, what kind? \_\_\_\_\_

How often? \_\_\_\_\_

When did you start? \_\_\_\_\_

### Energy

*Please rate the following:*

Daily energy level:

☐ Excellent   ☐ Fair  
☐ Good   ☐ Poor

Energy level after exercise:

☐ Excellent   ☐ Fair  
☐ Good   ☐ Poor

Daily stress level:

☐ Very High   ☐ Moderate  
☐ High   ☐ Low

General enjoyment of life:

☐ Excellent   ☐ Fair  
☐ Good   ☐ Poor

### Sleep/Rest

How much sleep do you get on average each night?

☐ >10 hours   ☐ 8-10 hours   ☐ 6-8 hours   ☐ <6 hours

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you wake during the night? ☐ Yes ☐ No

Difficulty falling back to sleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you have sleep apnea? ☐ Yes ☐ No

Do you use a cPAP machine? ☐ Yes ☐ No

Do you use any sleep aids? ☐ Yes ☐ No   Explain \_\_\_\_\_

### Stress/Coping

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No If yes, please describe: \_\_\_\_\_

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

Daily Stressors: Rate from 1-10 (10 being highest)

Work \_\_\_\_ Family \_\_\_\_ Social \_\_\_\_ Finances \_\_\_\_ Health \_\_\_\_ Other \_\_\_\_

Do you practice meditation or relaxation technique? ☐ Yes ☐ No If yes, how often? \_\_\_\_\_

Check all that apply:

☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other \_\_\_\_\_

☐ Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐ Yes ☐ No

### Dental History

☐ Silver mercury fillings? How many? \_\_\_\_\_ ☐ Gold fillings ☐ Root canals ☐ Implants

☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Problems chewing

Do you floss regularly ☐ Yes ☐ No

☐ Other dental issues? \_\_\_\_\_

☐ Dental surgery? \_\_\_\_\_

### Allergies/Sensitivities

Food/Supplement/ Medication/Environmental	Reaction

## **Medical Information**

Please list all nutritional supplements, vitamins, prescriptions and over the counter medications that you take regularly, dosage and for what purpose. Attach a separate page, if necessary. Be sure to bring your supplement and medication bottles with you to your appointment.

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Who is your primary care physician?

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

When was the last time you had a complete physical? \_\_\_\_\_

Please list any disease, illness, or ailments in your immediate family  
(i.e. mother-breast cancer, father-type II diabetic, etc.)

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Please feel free to expand on any concerns you think are important and relevant to your health.

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# Nourishing Wellness

Good health is a choice you can make today!

## Medical History

Please check off any of the following past or current diagnosis or conditions.

KEY: ☐ = past condition ☐ = current condition

### Autoimmune/Inflammatory

- ☐ ☐ Autoimmune Disease
- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Environmental Allergies
- ☐ ☐ Food Allergies
- ☐ ☐ Herpes-Genital
- ☐ ☐ Immune Deficiency Disease \_\_\_\_\_
- ☐ ☐ Lupus
- ☐ ☐ Multiple Chemical Sensitivities
- ☐ ☐ Poor Immune Function (frequent infections)
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Severe Infectious Disease
- ☐ ☐ Other \_\_\_\_\_

### Cancer

- ☐ ☐ Breast Cancer
- ☐ ☐ Colon Cancer
- ☐ ☐ Lung Cancer
- ☐ ☐ Melanoma
- ☐ ☐ Ovarian Cancer
- ☐ ☐ Prostate Cancer
- ☐ ☐ Skin Cancer
- ☐ ☐ Other \_\_\_\_\_

### Cardiovascular

- ☐ ☐ Arrhythmia (irregular heart beat)
- ☐ ☐ Heart Attack
- ☐ ☐ High Cholesterol
- ☐ ☐ Hypertension (high blood pressure)
- ☐ ☐ Hypotension (low blood pressure)
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Stroke
- ☐ ☐ Other \_\_\_\_\_

### Endocrine/Metabolic

- ☐ ☐ Anorexia
- ☐ ☐ Binge Eating Disorder
- ☐ ☐ Bulimia
- ☐ ☐ Endocrine Problems

- ☐ ☐ Frequent Weight Fluctuation
- ☐ ☐ Hair Loss/Poor Hair Growth
- ☐ ☐ Hyperthyroidism (overactive thyroid)
- ☐ ☐ Hypoglycemia (low blood sugar)
- ☐ ☐ Hypothyroidism (low thyroid)
- ☐ ☐ Infertility
- ☐ ☐ Metabolic Syndrome  
(Insulin Resistance or Pre-Diabetes)
- ☐ ☐ Night Eating Syndrome
- ☐ ☐ Type 1 Diabetes
- ☐ ☐ Type 2 Diabetes
- ☐ ☐ Weight Gain
- ☐ ☐ Weight Loss
- ☐ ☐ Other \_\_\_\_\_

### Genital and Urinary Systems

- ☐ ☐ Bladder Infections (Cystitis)
- ☐ ☐ Gout
- ☐ ☐ Kidney Stones
- ☐ ☐ Urinary Tract Infections (frequent)
- ☐ ☐ Yeast infections (frequent)
- ☐ ☐ Other \_\_\_\_\_

### Gastrointestinal

- ☐ ☐ Celiac Disease
- ☐ ☐ Constipation
- ☐ ☐ Crohn's
- ☐ ☐ Diarrhea/Loose Stools
- ☐ ☐ Gas/Bloating/Indigestion
- ☐ ☐ Gastritis or Peptic Ulcer Disease
- ☐ ☐ GERD (reflux)
- ☐ ☐ Heart Burn
- ☐ ☐ Hemorrhoids
- ☐ ☐ Inflammatory Bowel Disease
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Malabsorption
- ☐ ☐ Parasites
- ☐ ☐ Ulcerative Colitis
- ☐ ☐ Other \_\_\_\_\_

KEY: ○ = past condition    □ = current condition

### Musculoskeletal/Pain

- □ Chronic Pain
- □ Fibromyalgia
- □ Osteoarthritis
- □ Other \_\_\_\_\_

### Neurologic/Mood

- □ ADD/ADHD
- □ Addiction (alcohol, drugs)
- □ ALS
- □ Anxiety or Nervousness
- □ Autism
- □ Bipolar Disorder
- □ Depression
- □ Emotional Problems (instability, sensitivity)
- □ Headaches
- □ Memory Problems
- □ Migraines
- □ Mild Cognitive Impairment
- □ Multiple Sclerosis
- □ Panic Attacks
- □ Parkinson's Disease
- □ Ringing in Ears
- □ Schizophrenia
- □ Seizures
- □ Severe Mood Swings
- □ Suicidal Tendencies
- □ Other \_\_\_\_\_

### Respiratory

- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Pneumonia
- □ Sinusitis (chronic)
- □ Sleep Apnea
- □ Other \_\_\_\_\_

### Skin/Nails

- □ Acne
- □ Cold Sores
- □ Eczema
- □ Dandruff

- □ Hives
- □ Nails (poor growth)
- □ Nails – (white spots)
- □ Psoriasis
- □ Other \_\_\_\_\_

### Other

- □ Anemia
- □ Fainting/Dizziness
- □ Gallbladder Problems
- □ Hepatitis
- □ Insomnia
- □ Jaundice
- □ Liver Problems
- □ Other \_\_\_\_\_

### Women - check any that pertain:

- □ Birth Control Pills, Patch, Ring
- □ Decreased Libido
- □ Endometriosis
- □ Fibrocystic Breasts
- □ Fibroids
- □ Heavy Periods
- □ Hot Flashes/Night Sweats
- □ Hysterectomy
- □ Infertility
- □ Irregular Periods
- □ Loss of Libido
- □ Loss of Periods
- □ Menopause
- □ Painful Intercourse
- □ Painful Periods
- □ PMS
- □ Polycystic Ovarian Syndrome (PCOS)
- □ Pregnant/Nursing
- □ Other \_\_\_\_\_

### Men – check any that pertain:

- □ Difficulty Urination
- □ Difficulty with Erection
- □ Frequent Urination
- □ Loss of Libido
- □ Night Sweats
- □ Prostate Enlargement
- □ Other \_\_\_\_\_

### Surgeries

Check box if yes and provide date following type of surgery

- |                  |                                |
|------------------|--------------------------------|
| □ None           | □ Hysterectomy +/- Ovaries     |
| □ Angioplasty    | □ Joint Replacement (knee/hip) |
| □ Appendectomy   | □ Pacemaker                    |
| □ Dental Surgery | □ Stent                        |
| □ Gallbladder    | □ Tonsillectomy                |
| □ Heart Surgery  | □ Other _____                  |
| □ Hernia         |                                |



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## Symptom Survey

Rate each of the following symptoms based on your typical health profile for the past 30 days:

### Point Scale:

0 = Never or almost never have the symptom

1 = Occasionally have it, effect is not severe

2 = Occasionally have it, effect is severe

3 = Frequently have it, effect is not severe

4 = Frequently have it, effect is severe

### DIGESTIVE TRACT

- ☐ Nausea, vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating feeling
- ☐ Belching, passing gas
- ☐ Heartburn
- ☐ Intestinal/stomach pain

**Total** \_\_\_\_\_

### EARS

- ☐ Itchy ears
- ☐ Earaches, ear infections
- ☐ Drainage from ear
- ☐ Ringing in ears, hearing loss

**Total** \_\_\_\_\_

### EMOTIONS

- ☐ Mood Swings
- ☐ Anxiety, fear, nervousness
- ☐ Anger, irritability, aggressiveness
- ☐ Depression

**Total** \_\_\_\_\_

### ENERGY/ ACTIVITY

- ☐ Fatigue, sluggishness
- ☐ Apathy, lethargy
- ☐ Hyperactivity
- ☐ Restlessness

**Total** \_\_\_\_\_

### EYES

- ☐ Watery or itchy eyes
- ☐ Swollen, reddened or sticky eyelids
- ☐ Bags or dark circles under eyes
- ☐ Blurred or tunnel vision (does not include near or farsightedness)

**Total** \_\_\_\_\_

### HEAD

- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness
- ☐ Insomnia

**Total** \_\_\_\_\_

### HEART

- ☐ Irregular or skipped heartbeat
- ☐ Rapid or pounding heartbeat
- ☐ Chest pain

**Total** \_\_\_\_\_

### JOINT/MUSCLE

- ☐ Pain or aches in joints
- ☐ Arthritis
- ☐ Stiffness or limitation of movement
- ☐ Pain or aches in muscles
- ☐ Feeling of weakness or tiredness

**Total** \_\_\_\_\_

### LUNGS

- ☐ Chest congestion
- ☐ Asthma, bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing

**Total** \_\_\_\_\_

### MIND

- ☐ Poor memory
- ☐ Confusion, poor comprehension
- ☐ Poor concentration
- ☐ Poor physical coordination
- ☐ Difficulty making decisions
- ☐ Stuttering or stammering
- ☐ Slurred speech
- ☐ Learning disabilities

**Total** \_\_\_\_\_

### MOUTH/THROAT

- ☐ Chronic coughing
- ☐ Gagging, frequent need to clear throat
- ☐ Sore throat, hoarseness, loss of voice
- ☐ Swollen or discolored tongue, gums, lips
- ☐ Canker sores

**Total** \_\_\_\_\_

### NOSE

- ☐ Stuffy nose
- ☐ Sinus problems
- ☐ Hay fever
- ☐ Sneezing attacks
- ☐ Excessive mucus formation

**Total** \_\_\_\_\_

### SKIN

- ☐ Acne
- ☐ Hives, rashes, dry skin
- ☐ Hair loss
- ☐ Flushing, hot flashes
- ☐ Excessive sweating

**Total** \_\_\_\_\_

### WEIGHT

- ☐ Binge eating/drinking
- ☐ Craving certain foods
- ☐ Excessive weight
- ☐ Compulsive eating
- ☐ Water retention
- ☐ Underweight

**Total** \_\_\_\_\_

### OTHER

- ☐ Frequent illness
- ☐ Frequent or urgent urination
- ☐ Genital itch or discharge

**Total** \_\_\_\_\_

**GRAND Total** \_\_\_\_\_





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## Client Agreement

I, \_\_\_\_\_ fully understand the following:

- Linda Howes is a Certified Nutritionist and Holistic Health Practitioner and not a medical practitioner. Her approach is to assist the body's natural ability to heal itself using a variety of natural health techniques. The services she provides are for nutritional and educational purposes only.
- Any exchange of personal and professional information is strictly confidential on behalf of Linda Howes, CN, HHP and myself.
- Any documents or educational materials are for my personal use and are not to be duplicated.
- If I am unable to keep my appointment time I will kindly give at least 24 hours notice or I will be charged for the time reserved.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



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## Insurance Information

### Patient Information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ M: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell: \_\_\_\_\_ Fax #: \_\_\_\_\_

### Insurance Company Information

Insurance company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

### Card Holder Information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ M: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Card Holder's Employer:** \_\_\_\_\_

### HIPAA Release

I hereby authorize the release to my insurance company and other practitioners pertinent information related to my claim and/or treatment.

Print Name: \_\_\_\_\_ Sign Name: \_\_\_\_\_

Date: \_\_\_\_\_