



Nourishing Wellness

Good health is a choice you can make today!

Nutritional Consultation Questionnaire

General Information

Date _____

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:

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 |
|----------------------------------------------|----------|
| | |
| | |
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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.

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.)

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



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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

- | | |
|-----------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Hysterectomy +/- Ovaries |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Joint Replacement (knee/hip) |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Dental Surgery | <input type="checkbox"/> Stent |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> 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 you must change an appointment please do so as far in advance as possible. If you fail to show up or give less than 48 hours notice, you agree be charged a \$50 cancellation fee. Thank you for your understanding and cooperation.

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: _____