



# 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?

- Sugar  Meat  Fat  Chocolate  Fish  Alcohol
- Desserts  Milk  Salt  Bread  Fried Foods  Other \_\_\_\_\_

Which oils do you use/consume?

- Butter  Peanut Oil  Canola  Margarine  Corn Oil  Sun/Safflower
- Olive Oil  Crisco  Mayonnaise  Coconut Oil  Vegetable Oil  Flaxseed Oil
- Soybean Oil  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:

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

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 \_\_\_\_\_







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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: \_\_\_\_\_