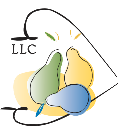
TO YOUR HEALTH! NUTRITION
Rebalancing Chronic Disease through Personalized Nutrition



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Client Intake Form

Print out this form, fill it out, and return it to To Your Health! two to three days before your appointment. Thank you.

General Information

Name:		Date:
Telephone: Home		Email Address:
Work		Would you like to receive the TYH e-newsletter?
Cell		How would you prefer to be contacted: Email Phone
Mailing Address:		Who referred you?
Gender: M ☐ F ☐	Age: Birthdate:	Ethnicity:
Height:	Weight:	Frame Size: Marital status:
Primary Doctor:		Phone number:

What is your occupation?

What do you hope to achieve from your visit?

If you had a magic wand and you could erase three problems what would they be?
1.
2.
3.

When was the last time you felt really well?

Did something trigger the change in your health?

What makes you feel worse?

What makes you feel better?

List current and on-going health and lifestyle problems in order of their priority:

Describe Problem:	Mild	Moderate	Severe	Prior Treatment (success)	Excellent	Good	Fair	None
Example: Post nasal drip		*X*		*Antihistamines*		*X*		
	☐	☐	☐		☐	☐	☐	☐
	☐	☐	☐		☐	☐	☐	☐
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Daily Activities		
Hours in a regular work week:	Activity level and work conditions (check all that apply): ☐ Sitting ☐ Mixture sitting/walking ☐ Lifting/carrying ☐ Driving ☐ Computer ☐ Fluorescent lights ☐ Construction/Manual labor ☐ Outside ☐ Other:	
When is your usual bedtime?	When is your usual rising time?	Do you use an alarm to wake up?
How well do you sleep?	Trouble falling asleep ☐ Trouble staying asleep ☐ Restless sleep ☐	
List your regular physical exercise:		
How many days per week do you exercise?		What is the average duration of your exercise?
List your other hobbies/recreation:		
How often performed?		
On a scale of 1 to 10 (10 being the most stressed), how stressed are you?		
List your stressors:		

General Medical		
How would you describe your health in general?		
What are your main symptoms?		
What initiates/aggravates them?		
Severity: Mild Severe Interferes with my life		
Do you smoke tobacco now? In the past?	How much?	
Do you drink alcohol?	What type?	How often?
Do you use recreational drugs?	What type?	How often?

Health History (Please note condition for yourself and/or family members and describe)									
Condition	Self	Sibling	Parent	Grand Parent	Condition	Self	Sibling	Parent	Grand Parent
Heart/Blood Vessels	☐				**Abdominal of Intestinal**	☐			
Describe:					Describe:				
Bones/Skeletal	☐				**Emotional**	☐			
Describe:					Describe:				
Kidneys/Bladder	☐				**Weight loss/Gain**	☐			
Describe:					Describe:				
Genital/ Reproductive	☐				**Allergies**	☐			
Describe:					Describe:				
Lungs/Chest	☐				**Cancer**	☐			
Describe:					Describe:				

Head, Sinus, Ears	☐	none	none	none	**Diabetes**	☐	none	none	none
Describe:					Describe:				
Bowel changes, blood in stool	☐				**Chronic colds/ Infections**	☐			
Describe:					Describe:				
Brain/ Neurological	☐				**Arthritis**	☐			
Describe:					Describe:				
Eyes	☐				**Hepatitis**	☐			
Describe:					Describe:				
Skin	☐				**HIV/AIDS**	☐			
Describe:					Describe:				
Autoimmune	☐				**Thyroid/Adrenal**	☐			
Describe:					Describe:				
Drug Abuse	☐				**Alcoholism**	☐			
Describe:					Describe:				

Health History (cont.)

List any dental work you have had done in the last 5 years:

Do you have any amalgam (silver) fillings?	How many?
List any surgeries you have had below:	Year of surgery:
When was the last time you were on a course of antibiotics?	What were they prescribed for?

How many courses of antibiotics have you been on in your lifetime? ☐ 0 to 3 ☐ 4 to 10 ☐ 10+

Symptoms Questionnaire *(Scoring menu: 0=least/never 1=light/rarely 2=moderate/occasionally 3=severe/always)*			
Colon Health		**Hypoacidity of the Stomach**	
Feeling that bowels do not empty completely		*Excessive belching, burping, or bloating*	
Lower abdominal pain relief by passing gas or stool		*Gas immediately following a meal*	
Alternating constipation and diarrhea		*Offensive breath*	
Diarrhea		*Sense of over-fullness after meals*	
Constipation		*Difficulty digesting fruits and vegetables (undigested food in stool)*	
Hard dry or small stool		*Protein feels like it "just sits" in stomach*	
Large amounts of foul smelling gas		*Poor appetite*	
Laxative use		*Stomach upsets easily*	
Frequent/recurrent infections or colds		*History of constipation*	
Yeast infections or fungal infections		*Known food allergies*	
Total		*Total*	
Hyperacidity of the Stomach		**Blood Sugar Balance**	
Stomach pain, burning, or aching 1-4 hours after meal		*Crave sweets during the day*	
Stomach pain before meals		*Heart palpitates if meals are missed*	
Antacid use		*Irritable if meals are missed*	
Feeling hungry an hour or two after eating		*Depend on coffee or sodas to keep yourself going in the afternoon or get started in morning*	
Heartburn when lying down or bending forward		*Get lightheaded, dizzy, and/or shaky if meals are missed*	
Temporary relief from antacids, food, milk, carbonated beverages		*Eating relieves fatigue*	
Digestive problems subside with rest and relaxation; increase with stress		*Feel shaky, jittery, tremors*	
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, caffeine		*Agitated, easily upset, nervous, anxious*	
Burping or bloating		*Poor memory, forgetful*	
Sudden acute indigestion		*Blurred vision*	
Aspirin or NSAID (ibuprophen, Tylenol, etc) use		*Wake at night, hard to get back to sleep*	
Family history of ulcer or gastritis		*Often have to eat in the middle of the night*	
Current ulcer		*Frequent unrealistic fears or worries*	
Total		*Fatigue after meals*	
Adrenal Function		*Eating sweets does not relieve cravings for sugar*	
Cannot stay asleep		*Must have sweets after meals*	
Crave salt		*Waist girth is equal or larger than hip girth*	
Slow starter in the morning		*Frequent urination*	
Afternoon fatigue		*Increased thirst and appetite, always*	

		hungry	
Dizziness when standing up quickly		Difficulty losing weight	
Afternoon headaches		Excessively weak for no apparent reason	
Headaches with exertion or stress		Moody or depressed	
Weak and/or ridged nails		Get sleepy or drowsy after lunch	
Low blood pressure		***Total***	
Weakness after colds or slow recovery			
Poor circulation		Tired, sluggish, reduced initiative	
Susceptible to colds, asthma, or bronchitis		Feel cold – hands, feet, all over	
Difficulty holding chiropractic adjustments		Require excessive amounts of sleep to function properly	
Cannot fall asleep		Increase in weight gain even with low-calorie diet	
Perspire easily		Difficulty losing weight	
Under high amounts of stress		Difficult, infrequent bowel movements, constipation	
Weight gain when under stress		Depression, lack of motivation	
Wake up tired even after six or more hours of sleep		Morning headaches that wear off as day progresses	
Excessive perspiration or perspiration with little or no activity		Outer third of eyebrow thins	
Increased blood pressure		Thinning of hair on scalp, face or genitals, or excessive falling hair	
Headaches		Dryness of skin and/or scalp	
Hot flashes		Mental sluggishness	
Total		Ringing in ears or noises in head	
Nutritional Deficiency		Hearing impaired	
Bruise easily		Heart palpitations	
Cannot recall dreams		Inward trembling	
Numbness in hands or feet		Increased pulse even at rest	
Muscle cramping while at rest or sleep		Nervous and emotional	
Strong light irritates eyes		Insomnia	
Crave chocolate		Night sweats	
Tendency toward anemia		Difficulty gaining weight	
White spots on fingernails		Reproductive hormone imbalance	
Reduced sense of taste and/or smell		Intolerant of high temperatures	
Susceptible to colds, infections		Easily flushed	
Total		***Total***	

GI History	
Foreign Travel? Where?	When?
Wilderness Camping? Where?	When?
Have you ever had **severe:** Gastroenteritis?	Diarrhea?
Do you feel you digest your meals well?	Do you feel bloated after mea

Client Birth History	
Was your birth full-term ☐ or premature ☐?	C-section ☐ or natural ☐ ?
Did your mother have any pregnancy complications? no	What were they?
Birth complications?	What were they?
Were you breast-fed? How long?	Bottle-fed? How long?
Age of introduction of: Solid food? Wheat? Dairy?	
Did you eat a lot of candy and sugar as a child?	Soda? Snacks or fast food?
Were you sedentary ☐ or active ☐ as a child?	

Medications/Supplements	Dosage	How often	Reason for use
If more room is needed, please create an attachment to the email…thanks			

Nutrition and Eating Habits			
On average, how many times per week do you:			
Cook full meals at home?	Eat alone?	Shop for food?	Eat and work simultaneously?
Eat in a restaurant?	Eat breakfast?	Eat in the car?	Eat meat (animal flesh)?
How often do you have a bowel movement?	Describe any problems with your bowel movements?		
Do you drink coffee?		How much per day?	
Do you drink sodas?		How many per day?	

How much water do you drink per day?	What type of water do you drink?
List 10 of your favorite foods:	
List foods that you absolutely will not eat:	
Describe and average breakfast (be as realistic as possible):	
Describe an average lunch:	
Describe an average dinner:	
Do you eat snacks?	What times of the day?
Describe an average snack:	

Eating patterns (check all that apply)			
☐ Emotional Eater	☐ Forget to eat	☐ Hungry all of the time	☐ Eat out of boredom
☐ No joy in eating	☐ Eat out of necessity	☐ Don't know when to stop	☐ Love well prepared food
☐ Healthy eating habits	☐ I eat too much	☐ I eat just enough	☐ I don't eat enough
☐ Late night eating	☐ Poor snack choices	☐ Travel frequently	☐ Reliance on convenience foods
☐ Don't care to cook	☐ Time constraints	☐ Family dictates food choices	☐ Struggle with eating issues

Comments on Eating Patterns:

Do you have any food allergies? What are they?

Do you have any seasonal allergies? Describe them:

Have you made any changes to your eating habits because of your health? Please describe:

Do you currently follow a special diet or nutritional program? If yes, check all that apply

☐ Low fat ☐ Low carbohydrate ☐ High protein ☐ Low sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat
☐ Gluten restricted ☐ Gluten-free ☐ No grains ☐ Vegetarian ☐ Vegan ☐ Specific weight loss program
Other:

What popular diets have you tried and what reactions did you have to them?

Where do you usually shop for food?	What is your weekly budget for food?
How many members in your family?	

Healthcare Goals

What are your healthcare goals?

Of these goals, which is your most important?

What is your timeframe for achieving these goals?

On a scale of 1 to 10 (10 being the most important), how important is that healthcare goal to your lifestyle?	On a scale of 1 to 10, how willing are you to change your diet/eating habits?
Briefly explain your answer:	Briefly explain your answer:

In order to change your health how willing are you to (scale of 1 to 10):		
Take several nutritional supplements each day?	Keep a record of what you eat 3 to 5 times per week?	Modify your lifestyle (e.g., sleep, work patterns)?
Practice a relaxation technique?	Engage in regular exercise/movement?	Have periodic lab tests to track progress (every 3 to 6 months)?

How do you see me helping with your health goals?

What are impediments to changes in your nutrition and lifestyle habits?

Any other comments:

Body Typing

There are several body typing techniques that have been developed. I have found that by combining blood typing, enzyme/endocrine typing, and metabolic typing I get a good overall picture of how your body processes food and what types of foods work best for your constitution. By answering the following questions, I can make a preliminary assessment as to your individual biochemistry and body type.

What is your blood type? (Don't worry if you don't know it, although I may ask you to determine your blood type later)

Section 1: Enzyme/Endocrine Typing

1. Which of the following best describes your body, especially when weight is gained?
   a. ☐ Gain weight evenly (may then stay in stomach area)
   b. ☐ Carry weight in hips and thighs, upper body stays thinner
   c. ☐ Carry weight in upper body, especially the stomach, legs stay thin with weight gain
   d. ☐ Remained similar since teens (slim & trim, heavy)
2. In which category is your favorite food?
   a. ☐ Carbohydrates (Vegetables/breads/pies/sweets)
   b. ☐ Rich foods, fatty foods, spicy foods
   c. ☐ Proteins (animal based)
   d. ☐ Dairy
3. Which foods give you problems? Do not check if no foods bother you.
   a. ☐ Carbohydrates (Vegetables/breads/pies/sweets)
   b. ☐ Rich foods, fatty foods, spicy foods
   c. ☐ Proteins (animal based)
   d. ☐ Dairy
4. Please check each category that contains health issues that you have experienced in either the past or the present. (Check all that apply)
   a. ☐ Allergies / cold hands and feet / depression / fatigue / headaches / hemorrhoids / low blood pressure / neck and shoulder aches / PMS / pancreatitis / skin eruptions / wheat intolerance (sprue) / upset stomach / ulcer
   b. ☐ Aching feet / arthritis / bladder infection / breast lumps / breast tumors / bypass surgery / cataracts / cirrhosis / cystitis / eczema / gallbladder problems / gallstones / hay fever / hepatitis / hives / jaundice / prostate problems / psoriasis / urinary problems
   c. ☐ Alcohol addiction / arteriosclerosis / back problems / Candidiasis / constipation / ear infections / heart disease / herniated disc / high blood pressure / insomnia / kidney disease / lower back ache / loss of hearing / osteoporosis or osteopenia / sciatica
   d. ☐ Aching knees / chronic allergies / colds / colitis / Crohn's disease / diarrhea to constipation / diverticulosis / irritable bowel/ milk intolerance

Section 2: Oxidative Typing

- Choose TRUE of FALSE to the answer that best describes you.
- If neither choice fits you exactly, try to choose the one that comes closest to your tendencies
- Try to answer the questions from your direct experience rather than from any preconceived ideas that you may have about the issue at hand: for example, you may believe that you should be eating low-fat foods but, in practice, fat-rich foods may actually agree with you; or you may think you are hungry between meals when, in fact, you may be eating out of habit or boredom – not because you are physically hungry.
- When responding to a statement phrased in the negative (e.g., "Vegetarian meals are not satisfactory to me") a TRUE answer would mean that you agree with the statement.

My appetite at breakfast is strong	True False
My appetite at lunch is strong	True False
My appetite at dinner is strong	True False
Going without food for four or more hours is uncomfortable	True False
I often get hungry and need to snack between meals	True False
I live to eat, rather than eat to live	True False
My cravings lean more toward meat and fat than carbohydrates (Don't think about sugar…more like fruits/vegetables/grain products)	True False
Vegetarian meals are not satisfactory to me	True False
Eating meat or fatty food restores my energy	True False
I prefer salty and/or fatty foods to sweet foods	True False
Fruits alone generally do not satisfy me	True False
Fasting is very difficult for me	True False
Eating before bedtime improves the quality of my sleep	True False
Orange juice in the morning does not agree with me	True False
Coffee tends to make me feel wired or jittery	True False
My eyes and/or nose tend to be moist	True False
I need to urinate often during the day	True False
I tend to cough or clear my throat fairly frequently	True False
I prefer to sleep in, in the morning	True False
If I cut myself, the wound heals quickly	True False

THREE-DAY DIET TRACKER

List all of the food and drink that you eat for three days. Please include snacks. State the approximate amount next to each food. (For instance, "Oatmeal – ½ cup")

	Time	Day One	Day Two	Day Three
Breakfast				
Lunch				
Dinner				
Snacks				

Comments: