Balance Health + Wellness Nutrition Intake Form

Please complete this form 24 hours prior to your scheduled appointment time.

Personal Information

Legal first name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Occupation

Hours per week

Referred by

Emergency Contact

Legal first name

Last name

Relationship

Home phone

Mobile phone

Email address

Primary Care Physician

Title

Legal first name

Last name

Work phone

Mobile phone

Fax number

Email address

Title/Occupation

Have you ever seen a Dietitian or Nutritionist? ◯ Yes ◯ No

If you have seen other practitioners for your health issues please list and indicate the results of their evaluations:

(i.e., Doctor, Chiropractor, Naturopath, Therapist, Homeopath, Massage Therapist, etc)

Health Goals

What do you want to achieve during your initial visit?

What are your top 3 goals for your health and wellness?
Please be specific.

How committed are you to making the changes needed to achieve your health goals?

- ◯ Very committed
- ◯ Somewhat committed
- ◯ Vary in my commitment
- ◯ Not sure

Please explain

What barriers are preventing you from reaching your health goals?
Please name at least 2.

Do you have a support system for your health changes?
Please describe how your family and friends have or have not helped you reach your health goals.

Lifestyle Habits

Sleep Habits

Sleep Concerns

- ☐ Difficulty falling asleep
- ☐ Snoring
- ☐ Daytime drowsiness
- ☐ Falling asleep while driving
- ☐ Frequent awakenings
- ☐ Breathing problems
- ☐ Non-restorative sleep
- ☐ None

Hours of sleep per night on weekdays:

Hours of sleep per night on weekends:

Further information on sleep concerns:

Exercise Habits

Do you currently exercise? ◯ Yes ◯ No

If no, do you have any physical limits on exercising?

If yes, what type of exercise do you do?

If yes, how many days/hours per week?

Stress Habits

How stressed are you?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

1 = Not stressed at all, 10 = Constantly under high levels of stress

What do you do for stress management?

Do you feel that stress has impacted your health? ○ Yes ○ No

Smoking Habits

Smoking status:

○ Current smoker
○ Former smoker
○ Never smoked

Former smokers: When did you quit?

Drinking and Drug Habits

Do you drink alcohol? ○ Yes ○ No

Do you use recreational drugs? ○ Yes ○ No

Diet History

Do you currently follow a specific diet?
(e.g.: Paleo, Vegan, Atkins, Low Fat, DASH)

◯ Yes ◯ No

Eating patterns.
Check all that apply:

- ☐ Eat too much
- ☐ Forget to eat
- ☐ Eat out of boredom
- ☐ Late night snacking
- ☐ Eat in the car
- ☐ Healthy choices
- ☐ Skip meals (indicate which meals below)
- ☐ Hungry after eating
- ☐ Wake up hungry at night
- ☐ Other
- ☐ Eat too little
- ☐ Emotional eater
- ☐ Hungry all the time
- ☐ Fast eater
- ☐ Poor choices
- ☐ No joy in eating
- ☐ Tired after eating
- ☐ Eating is out of control
- ☐ History of disordered eating

If you skip meals, please indicate which meals.

Other eating patterns not mentioned:
Please specify.

About how many (#) meals per week do you...

Eat that have been prepared at home?		Eat at restaurants, get take-out or eat food ready-made from the grocery store?	
Eat at fast-food type restaurants?			

Additional information?

Do you do most of the grocery shopping at home?

◯ Yes ◯ No

Do you feel that you have access to healthy food and the knowledge how to prepare them?

Do you have cravings for any of the following foods?
Yes/No

Sweet foods		Starchy foods	
Salty foods		Dairy	
Fried foods		Crunchy foods	
Other			

Are there any foods you could not give up for 2 weeks?

Do you have any food allergies/sensitivities?
If yes, please specify:

What are your allergy symptoms?

Anything else that would be helpful for me to know about your diet?

Family History

Father's health history

Please indicate the boxes that are applicable:

- ☐ Alcoholism or other substance abuse
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Dementia / Alzheimer's
- ☐ Epilepsy / Seizures
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Migraines
- ☐ Stroke
- ☐ Other
- ☐ Arthritis
- ☐ Asthma Autoimmune disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ High blood pressure
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Thyroid disorder

If "other", please specify

Mother's health history

Please indicate the boxes that are applicable:

- ☐ Alcoholism or other substance abuse
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Dementia / Alzheimer's
- ☐ Epilepsy / Seizures
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Migraines
- ☐ Stroke
- ☐ Other
- ☐ Arthritis
- ☐ Asthma Autoimmune disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ High blood pressure
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Thyroid disorder

If "other", please specify

Grandparent' health history

Please indicate the boxes that are applicable:

- ☐ Alcoholism or other substance abuse
- ☐ Arthritis

- [ ] Asthma
- [ ] Bleeding disorder
- [ ] Dementia / Alzheimer's
- [ ] Epilepsy / Seizures
- [ ] Heart disease
- [ ] Kidney disease
- [ ] Migraines
- [ ] Stroke
- [ ] Other
- [ ] Asthma Autoimmune disorder
- [ ] Cancer
- [ ] Diabetes
- [ ] Glaucoma
- [ ] High blood pressure
- [ ] Mental illness
- [ ] Osteoporosis
- [ ] Thyroid disorder

If "other", please specify

Child's health history

Please indicate the boxes that are applicable:

- [ ] Alcoholism or other substance abuse
- [ ] Asthma
- [ ] Bleeding disorder
- [ ] Dementia / Alzheimer's
- [ ] Epilepsy / Seizures
- [ ] Heart disease
- [ ] Kidney disease
- [ ] Migraines
- [ ] Stroke
- [ ] Other
- [ ] Arthritis
- [ ] Asthma Autoimmune disorder
- [ ] Cancer
- [ ] Diabetes
- [ ] Glaucoma
- [ ] High blood pressure
- [ ] Mental illness
- [ ] Osteoporosis
- [ ] Thyroid disorder

If "other", please specify

Sibling's health history

Please indicate the boxes that are applicable:

- [ ] Alcoholism or other substance abuse
- [ ] Asthma
- [ ] Bleeding disorder
- [ ] Dementia / Alzheimer's
- [ ] Epilepsy / Seizures
- [ ] Heart disease
- [ ] Kidney disease
- [ ] Arthritis
- [ ] Asthma Autoimmune disorder
- [ ] Cancer
- [ ] Diabetes
- [ ] Glaucoma
- [ ] High blood pressure
- [ ] Mental illness

- [ ] Migraines
- [ ] Stroke
- [ ] Other
- [ ] Osteoporosis
- [ ] Thyroid disorder

If "other", please specify

Personal Medical History

Allergies:
(dust, animals, foods, etc.)

Current Prescription Medications
Please include: Dose/Frequency

Current Supplements
Please include: Supplement, Brand, Dose/Frequency

Surgical History
Please include: Date, Description

Hopitalizations
Please include: Date, Description

Have you been diagnosed with any medical conditions?
Please fill in the blank with "C" for current conditions or "P" for past conditions:

Digestive Disorder		Acid Reflux	
Nausea		Vomiting	
Diarrhea		Constipation	
Anemia		Cancer	
Liver Disease		Diabetes	
Kidney Disease		Osteoporosis	
Hypertension		High Cholesterol	
Heart Disease		Stroke	
Thyroid Disease		Depression	
Anxiety		Substance Abuse	
Other			

If "other", please specify

Additional description of above conditions:

Signs and Symptoms

How many bowel movements do you have per day?

How would you describe your bowel movement?

- ☐ Strained
- ☐ Hard
- ☐ Explosive
- ☐ Blood in stool
- ☐ Other
- ☐ Loose
- ☐ Very thin
- ☐ Constipated
- ☐ Mucus in stool
- ☐ Normal

If "other", please specify

Check any symptoms you have had in the last 2 weeks:

General:

- ☐ Fatigue
- ☐ Frequent illness
- ☐ Drowsiness
- ☐ Allergy
- ☐ Feeling stressed
- ☐ Insomnia

Nose:

- ☐ Nosebleeds
- ☐ Congestion
- ☐ Sneezing
- ☐ Sinus problems
- ☐ Hay Fever
- ☐ Mucus

Eyes:

- ☐ Dry eyes
- ☐ Double vision
- ☐ Light sensitivity
- ☐ Pain or discomfort
- ☐ Watery / itchy eyes
- ☐ Blurred vision
- ☐ Change in vision
- ☐ Poor night vision

Throat / Neck:

- ☐ Swollen glands
- ☐ Mouth sores
- ☐ Snoring
- ☐ Gum disease

- [ ] Bleeding gums
- [ ] Throat clearing
- [ ] Hoarseness
- [ ] Dry mouth
- [ ] Coated tongue
- [ ] Sore Throat
- [ ] Difficulty swallowing

Lungs:

- [ ] Chronic cough
- [ ] Chest pain
- [ ] Allergies
- [ ] Phlegm
- [ ] Asthma

Musculoskeletal:

- [ ] Pain in joints
- [ ] Muscle cramps
- [ ] Muscle tenderness
- [ ] Swollen / stiff joints
- [ ] Fibromyalgia
- [ ] Back pain or stiffness

Skin:

- [ ] Acne
- [ ] Rashes
- [ ] Dry skin
- [ ] Hair loss
- [ ] Nail problems
- [ ] Excess hair growth
- [ ] Hives, cysts, boils
- [ ] Cold sores
- [ ] Dandruff
- [ ] Eczema or psoriasis
- [ ] Sun sensitivity

Emotional:

- [ ] Mood swings
- [ ] Depression
- [ ] Irritability
- [ ] Anxiety
- [ ] Anger

Heart:

- [ ] Irregular heartbeat
- [ ] Chest pain
- [ ] Faintness
- [ ] High blood pressure
- [ ] Palpitations
- [ ] Foot / ankle swelling
- [ ] Shortness of breath
- [ ] Low blood pressure

Blood:

- [ ] Easy bruising
- [ ] Anemia
- [ ] Easy bleeding
- [ ] Hemochromatosis (high iron)

- [ ] Numbness in extremities

Digestive:

- [ ] Appetite change
- [ ] Bad breath
- [ ] Diarrhea / loose stools
- [ ] Bloating / belching
- [ ] Heartburn / reflux
- [ ] Change in bowel habits
- [ ] Food sensitivity
- [ ] Nausea / vomiting
- [ ] Constipation
- [ ] Flatulence (gas)
- [ ] Abdominal pain
- [ ] Indigestion

Metabolic / Disordered eating:

- [ ] Food cravings
- [ ] Food restriction
- [ ] Unintended weight gain
- [ ] Excess urination
- [ ] Binge eating
- [ ] Unintended weight loss
- [ ] Excess thirst

Genitourinary:

- [ ] Bladder issues
- [ ] Kidney infections
- [ ] Chronic UTIs
- [ ] Kidney failure
- [ ] Kidney stones
- [ ] Burning urination

Women:

- [ ] Irregular periods
- [ ] Abnormal bleeding
- [ ] Endometriosis
- [ ] Genital itch / discharge
- [ ] Short luteal phase
- [ ] Fertility problems
- [ ] Yeast infections
- [ ] Hysterectomy
- [ ] Low sex drive

Men:

- [ ] Erectile dysfunction
- [ ] Low sex drive

Other symptoms?

For women only:

Are you currently pregnant? ◯ Yes ◯ No

Are you trying to become pregnant? ◯ Yes ◯ No

Are you currently breastfeeding? ◯ Yes ◯ No

Do you still have regular periods? ◯ Yes ◯ No

If you have children, what are their ages?

Date of last period

Any additional information you'd like to share?

Client

X

Print name: **Date:**