

Transformational HEALTHCARE

Nutrition Consult- NEW PATIENT INFORMATION FORM

Name _____ Date _____

Address _____ Apt # _____

City _____ State _____ ZIP _____

Shipping Address _____

Home Phone (____)____-____ Work Phone (____)____-____

e-mail address: _____

Would you like to receive our monthly informational newsletter * yes pls *no thank you

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Sex M/F Height _____ Weight _____

Overall Health (circle one) Excellent- Good- Fair- Poor- Other _____

Chief Complaint (reason you are here): (use separate sheet if more room is needed)

Previous treatments for this complaint: _____

Other complaints or problems: _____

Current Medications/drugs being taken: _____

Are you currently under the care of a physician or other health care professional? If yes please give name(s) and date of last visit(s): _____

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Name _____ Date _____

Nutritional Supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (If yes indicate how much)?

Cigarettes _____ Coffee _____ Alcohol _____ Other _____

HISTORY:

List any major illnesses (with approx. dates): _____

List any surgery or operations with approx. date: _____

Past accidents or injuries (with approx. dates): _____

List any known allergies (food, airborne, all others): _____

Please circle if any apply: * allergy to the daisy family * blood pressure problems
* history of edema * history of blood sugar imbalance *

Marital Status: S M D W Name of Partner _____

Describe health of spouse: _____ Number of children if any _____

Describe health or children _____

Any family history of serious illnesses (circle those that apply): Cancer/
Diabetes/ Heart/ Other _____

Any household pets or other animals you or family members are in close contact
with: _____

What can we do to make you happier? _____

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Office Policy

We value our patient's time as much as we do our own and pride ourselves on keeping your wait to a minimum. We understand travel in Manhattan can be challenging and will accommodate a late arrival for a scheduled appointment the best we can.

You are responsible for payment of missed appointments or appointments rescheduled with less than 24 hours notice; however we will make every effort to fill that time for you. Payment is expected at the time service is rendered. We accept credit cards (Visa, Mastercard, American Express) cash or personal checks.

Signature

Date

The purpose of this visit is for a nutritional consult only and is not a substitute for a visit to your primary health care provider.

Signature

Date

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Name: _____ Date: _____

Do you have any scars on your body that never felt like they healed properly?

Do you have any metal amalgams in your teeth or been exposed to chemicals or metals?

What is your stress level?

1-10 (10 being high stress)

% of time you experience each

1. In general
2. At its "worst"
3. At its "best"

Is there anything else you would like to tell us?

(TIME) DAY 1

(TIME) DAY 2

(TIME) DAY 3

() Breakfast:

() Snack:

() Lunch:

() Snack:

() Dinner:

() Snack:

symptom survey form

Name _____ Doctor. _____ Date _____

Age _____ sex: ___ M. ___ F. phone # _____

Instructions: Number the boxes which apply to you with either a 1, 2, or 3

1 - for mild symptoms

2 - for moderate symptoms

3 - for severe symptoms

Leave the box blank if it does not apply to you

Group 1	Group 2	Group 3
<input type="checkbox"/> acid foods upset	<input type="checkbox"/> Joint stiffness death arising	<input type="checkbox"/> Eat when nervous
<input type="checkbox"/> get chilled often	<input type="checkbox"/> Muscle leg toe cramps at night	<input type="checkbox"/> Excessive appetite
<input type="checkbox"/> Lump in throat	<input type="checkbox"/> Butterfly stomach, cramps	<input type="checkbox"/> Hungry between meals
<input type="checkbox"/> dry mouth eyes nose	<input type="checkbox"/> Eyes or nose water	<input type="checkbox"/> Irritable before meals
<input type="checkbox"/> pulse beat after meals	<input type="checkbox"/> Eyes blinked often	<input type="checkbox"/> Get shaky if hungry
<input type="checkbox"/> Keyed up-failed to calm	<input type="checkbox"/> Eyelids swollen, puffy	<input type="checkbox"/> Fatigue, eating relieves
<input type="checkbox"/> Cuts heal slowly	<input type="checkbox"/> Indigestion soon after meals	<input type="checkbox"/> Lightheaded if meals delayed
<input type="checkbox"/> Gags easily	<input type="checkbox"/> Away seems hungry: feel lightheaded often	<input type="checkbox"/> Heart palpitations if meals missed or delayed
<input type="checkbox"/> Unable to relax, startles easily	<input type="checkbox"/> Digestion problems	<input type="checkbox"/> Afternoon headaches
<input type="checkbox"/> Extremities cold calming clammy	<input type="checkbox"/> Vomiting frequent	<input type="checkbox"/> Over eating sweets upsets
<input type="checkbox"/> Strong light irritates	<input type="checkbox"/> Hoarseness frequent	<input type="checkbox"/> Awakened after a few hours sleep-hard to get back to sleep
<input type="checkbox"/> Urine amount reduced	<input type="checkbox"/> Breathing irregular	<input type="checkbox"/> Crave candy or coffee and afternoons
<input type="checkbox"/> Heart pounds after retiring	<input type="checkbox"/> Pulse slow, feels irregular	<input type="checkbox"/> Moods of depression-blues or melancholy
<input type="checkbox"/> Nervous stomach	<input type="checkbox"/> Gagging reflex slow	<input type="checkbox"/> Abnormal craving for sweets or snacks
<input type="checkbox"/> Appetite reduced	<input type="checkbox"/> Difficulty swallowing	
<input type="checkbox"/> Cold sweats often	<input type="checkbox"/> Constipation or diarrhea alternating	
<input type="checkbox"/> Fever easily raised	<input type="checkbox"/> Slow starter	
<input type="checkbox"/> Neuralgia-like pains	<input type="checkbox"/> Get chilled infrequently	
<input type="checkbox"/> Staring blinks little	<input type="checkbox"/> Perspire easily	
<input type="checkbox"/> Sour stomach frequent	<input type="checkbox"/> Circulation poor, sensitive to cold	
	<input type="checkbox"/> Subject calls, asthma, bronchitis	

Group 4

- ___ Hands and feet go to sleep, numbness
- ___ Sigh frequently, air hunger
- ___ Aware of breathing heavily
- ___ High-altitude discomfort
- ___ Open windows in close rooms
- ___ Susceptible to cold and fever's
- ___ Afternoon yawner
- ___ Get drowsy often
- ___ Swollen ankles worse at night
- ___ Muscle cramps, worse during exercise get "Charlie horses"
- ___ Shortness of breath on exertion
- ___ Dull pain in chest or radiating into left arm, worse on exertion
- ___ Bruise easily, black and blue spots
- ___ Tendency to anemia
- ___ Nose bleeds frequent
- ___ Noises and head or ringing in ears
- ___ Tension on the breastbone or feeling uptight, worse on exertion

Group 5

- ___ Dizziness
- ___ Dry skin
- ___ Burning feet
- ___ Blurred vision
- ___ Itching skin and feet
- ___ Excessive falling hair
- ___ Frequent skin rashes
- ___ Bitter, metallic taste in mouth mornings
- ___ Bowel movement painful or
- ___ Worries, feel insecure
- ___ Feeling queasy: headaches over eyes
- ___ Greasy foods upset
- ___ Stools light-colored
- ___ skin peels on food souls
- ___ pain between shoulder blades
- ___ use laxatives
- ___ stools alternate from soft, watery
- ___ gallbladder attacks and gallstones
- ___ sneezing attacks
- ___ difficult dreaming, nightmare
- ___ bad breath
- ___ milk products cause distress
- ___ sensitive to hot weather
- ___ burning or ditching anus
- ___ Crave sweets

Group 6

- ___ Loss of taste for meat
- ___ Lower bowel gas several hours after eating
- ___ Burning stomach sensation, eating relieves
- ___ Coated tongue
- ___ Pass large amounts of foul-smelling gas
- ___ Indigestion ½ - 1 hour after eating, maybe up to 3-4 hours
- ___ Mucus colitis or irritable bowel
- ___ Get shortly after eating
- ___ Stomach bloating after eating

Group 7

A

- ___ Insomnia
- ___ Nervousness
- ___ Can 't gain weight
- ___ Intolerance the heat
- ___ Highly emotional
- ___ Flush easily
- ___ Night sweats
- ___ Thin, moist skin
- ___ Inward trembling
- ___ Heart palpitates
- ___ Increased appetite without weight gain
- ___ Pulse fast at rest
- ___ Eyelids and face twitch
- ___ Irritable and restless
- ___ Can't work under pressure

B

- ___ Increased scratch that increase in weight
- ___ Decrease appetite
- ___ Fatigue easily
- ___ Ringing ears
- ___ Sleep during Day
- ___ Sensitive to cold
- ___ Dry scaly skin
- ___ Constipation
- ___ Metal sluggishness
- ___ Hair coarse, falls out
- ___ Headaches upon arising where over during day
- ___ Slow polls, below 65
- ___ Frequency of urination
- ___ Impaired hearing
- ___ Reduced initiative

Group 7 (continued))

C

- ___ Failing memory
- ___ Low blood pressure
- ___ Increase sex drive
- ___ Headaches, splitting or rendering type
- ___ Decrease sugar tolerance

D

- ___ Abnormal thirst
- ___ Bloating of abdomen
- ___ Weight gain around hips or waist
- ___ Sex drive reduced or lacking
- ___ Tendency to ulcer, colitis
- ___ Increase sugar tolerance
- ___ Women: menstrual disorders
- ___ Young girls:: lack of menstrual I function

E

- ___ Dizziness
- ___ Headaches
- ___ Hot flashes
- ___ Increased blood pressure
- ___ Hair growth of face or body (female)
- ___ Sugar in urine (not diabetes)
- ___ Masculine tendencies (female)

F

- Weakness dizziness
- Chronic fatigue
- Low blood pressure
- Nails weak, ridged
- Tendency to hives
- Arthritic tendencies
- Perspiration increase
- Bowel disorders
- Poor circulation
- Swollen ankles
- Crave salt
- Brown spots or bronzing of skin
- Allergies-tendency to asthma
- Weakness after colds, influenza
- Exhaustion-muscular and nervous
- Respiratory disorders

Female only

- Very easily fatigued
- Premenstrual tension
- Painful menses
- Depressed feeling before menstruation
- Menstruation excessive and prolonged
- Painful breast
- Menstruate too frequently
- Vaginal discharge
- Hysterectomy/ovaries removed
- Menopausal hot flashes
- Menses scanty or missed
- Acne, worse at menses
- Depression a long-standing

Important

To the patient: please list below
 The five main health complaints you
 Have in order of their importance:

- 1 - _____

- 2 - _____

- 3 - _____

- 4 - _____

- 5 - _____

Males only

- Prostate trouble
- Urination difficult or dribbling
- Night urination frequent
- Depression
- Pain on inside of the legs or heels
- Feeling of incomplete bowel evacuation
- Lack of energy
- Migrating aches and pains
- Tire too easily
- Avoid activity
- Leg nervousness at night
- Diminished sex drive