

Name _____	Date of first visit _____
Address _____	City/State/Zip _____
Phone (home) _____	(work) _____
(cell) _____	Email _____
Age _____	Date of birth _____
Gender: Female _____	Male _____
Single _____	Married _____
Separated _____	Divorced _____
Widowed _____	Partnership _____
Live with: Spouse _____	Partner _____
Parents _____	Children _____
Friends _____	Alone _____

Nutrition Counseling Intake Form
Please return this form prior to your first visit.

Occupation _____ Employer _____

How did you hear about our clinic? _____

Emergency contact: Name _____ Phone _____

Relationship _____

Primary Care Provider: Name _____ Phone _____

What are your most important health concerns? List in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Please describe any important events which may have contributed to any of the above problems:

If you have seen other practitioners for these problems, indicate when and for how long, along with the results of these evaluations or treatments: _____

Please list some goals regarding what you hope nutrition counseling will help you achieve.

Height _____ Weight _____ Max weight & when _____ Goal weight _____

Hospitalizations and Surgeries (types and dates):

Y = condition you have now For the following, please circle:
 P = condition you had in the past N=never had the condition

MENTAL/EMOTIONAL

Treated for emotional problems	Y	P	N	Depression	Y	P	N
Mood Swings	Y	P	N	Anxiety or nervousness	Y	P	N
Tension	Y	P	N	Memory problems	Y	P	N
Poor concentration	Y	P	N	Seasonal Depression	Y	P	N

ENDOCRINE

Hypothyroid	Y	P	N	Heat or cold intolerance	Y	P	N
Hypoglycemia	Y	P	N	Diabetes	Y	P	N
Excessive thirst	Y	P	N	Excessive Hunger	Y	P	N
Fatigue	Y	P	N				

CARDIOVASCULAR

Heart disease	Y	P	N	Fainting	Y	P	N
High/Low blood pressure	Y	P	N	Palpitations/fluttering	Y	P	N
Blood clots	Y	P	N	Chest pain	Y	P	N

GASTROINTESTINAL

Trouble swallowing	Y	P	N	Heartburn	Y	P	N
Change in appetite	Y	P	N	Ulcer	Y	P	N
Nausea	Y	P	N	Vomiting (illness or induced)	Y	P	N
Blood in stool	Y	P	N	Bowel Movements How often _____ Is this a change? _____			
Pain or cramps	Y	P	N	Constipation	Y	P	N
Belching or passing gas	Y	P	N	Diarrhea	Y	P	N
Black stools	Y	P	N	Gall Bladder disease	Y	P	N
Jaundice (yellow skin)	Y	P	N	Liver Disease	Y	P	N

Current Medications:

Name	Dosage
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Please indicate if you or a family member has had any of the following now or in the past, along with **years affected** if known:

Self	Specified Relative	Disease
		Alcoholism
		Anemia
		Anorexia
		Arthritis
		Asthma
		Binge Eating
		Bulimia
		Cancer
		Compulsive overeating
		Crohn's Disease/Colitis
		Depression
		Diabetes
		Food Allergies or Sensitivities
		Heart Disease
		Hepatitis
		Herpes
		High Blood Pressure
		High Cholesterol
		HIV
		Hypoglycemia
		Irritable bowel syndrome
		Kidney disease
		Lupus
		Lyme disease
		Mental illness
		Migraine Headaches

		Multiple sclerosis
		Stomach/Intestinal Ulcers
		Stroke
		Substance Abuse
		Thyroid disease

Nutritional Supplements (such as vitamins):

Name	Dosage	For What?

Please list any allergies especially to medications: _____

Tobacco:

Do you currently smoke? _____ Chew? _____
 If yes to either, how much daily and for how long have you been doing so? _____

If no, did you ever smoke or chew/for how long/when did you stop? _____

Recreational Drug Use Type and frequency _____
 Have you ever been treated for substance abuse. If yes, where and when _____

Exercise: Do you currently exercise? If yes, please explain _____

Sleep: Average amount of sleep per night: _____
 Do you fall asleep easily? Y or N Do you wake often during the night? Y or N
 Do you wake up feeling rested? Y or N

Method of payment for first visit _____

Consent for Treatment: I, the undersigned, have voluntarily applied for and agree to participate in treatment at Johnson Chiropractic and Wellness Clinic at Longwood, FL. The ultimate responsibility of the fees is that of the undersigned client. CLIENTS ARE REQUESTED TO PROVIDE 24 HOURS NOTICE CANCELLATION. WITHOUT SUCH NOTICE CLIENTS WILL BE BILLED FOR THE PROFESSIONAL TIME AT THE REGULAR HOURLY RATE. Your signature indicates your understanding and acknowledgment of the foregoing information.

Please sign: _____ Date: _____

Nutritional Intake – Food Frequency List

Name: _____ Date: _____

Please record how frequently you consume the following items by checking off the appropriate columns and indicating specific types and comments.

	More than once per day	Once daily	A few times/ week	A few times/ month	Once per month	A few times per year	Do not consume	Types & comments
BEVERAGES								
Alcohol								
Coffee								
Decaf Coffee								
Soda								
Diet Soda								
Green Tea								
Herbal Tea								
Iced Tea								
Sweetened Beverage								
Diet Sweetened Bev.								
Juice								
Water and # of oz								
PROTEINS								
Beef								
Chicken								
Turkey								
Pork								
Ham								
Fish								
Seafood								
Eggs								
Tofu								

GRAINS								
Whole grain breads								
White Bread								
Cereal								
Pasta								
	More than once per day	Once daily	A few times/week	A few times/month	Once per month	A few times per year	Do not consume	Types & comments
Rice								
Oatmeal								
Other grains								
FATS								
Butter								
Margarine								
Fried foods								
Nut butters								
Nuts/seeds								
Olive oil								
Other oil								
Mayonnaise								
Salad Dressing								
DESSERTS								
Cake								
Cookies								
Pie								
Ice Cream								
Frozen Yogurt								
Candy								
Chocolate								
Pastry/Donut								
Diet or artificially sweetened desserts								
Other								

FIBER								
Beans or legumes								
Fresh or frozen fruit								
Canned fruit								
Dried fruit								
	More than once per day	Once daily	A few times/week	A few times/month	Once per month	A few times per year	Do not consume	Types & comments
Fresh Vegetables								
Frozen vegetables								
Canned vegetables								
Leafy greens								
MISCELLANEOUS								
Diet Foods								
Frozen dinners								
Diet frozen foods								
Pizza								
Sugar subs-artificial								
Organic products								
Soy products								
Vegetarian alternatives								
DAIRY								
Cow's milk								
Cheese								
Plain yogurt								
Sweetened yogurt								
Artificially sweetened yogurt								
Milk Alternative								
SNACK FOODS								
Chips								
Pretzels								

Tortilla chips								
Popcorn								
Crackers								
Other snack foods								
	More than once per day	Once daily	A few times/week	A few times/month	Once per month	A few times per year	Do not consume	Types & comments
EATING OUT Restaurant Foods								
Fast foods								

Are you currently following any special dietary guidelines, including vegetarianism/veganism? If yes, please explain in detail.

If you compulsively overeat, what foods are you most likely to consume during such episodes?

Do you experience food cravings? If yes, please explain.

Please record an example of one day of what you usually eat, indicating approximate time, location, food item and amount from getting up in the morning until going to bed. If your intake varies from day to day please list two days.