Nutrition Case History

Nutritional Wellness Center

Instructions:

~ Bring all medications, vitamins, minerals and supplements you are currently taking.

~ Please don't take anything, except necessary medication for 24 hours before your appointment.

~ Avoid lotions on your hands and feet the day of testing.

~ Drink water before your appointment as dehydration makes it difficult to obtain accurate readings.

~ Please eat within two hours of your appointment so your blood sugar is level.

~ It is recommended that you wear light colored cotton clothing.

Waiver of Liability Form for Nutrition Services Rendered at Nutritional Wellness Center (NWC)

I, the client, choose to receive a nutrition status screening using a Nutrition Response Testing (Applied Kinesiology protocol) or N E T (Neuro Emotional Technique) and/or HRV (Heart Rate Variability Testing). The opinions received may include information on stress reduction, nutritional suggestions, including supplements or homeopathic remidies

I understand that NWC does not treat, diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. NWC is not a primary care facility and the treatments are natural and holistic. The nutrition visit at NWC is provided to clients on a cash basis; we do not file or submit insurance claims.

I acknowledge that any opinions from NWC are not a substitute for medical examination or diagnosis, and it is recommended that I see a primary health care provider for that type of service. Any opinions on dietary changes or restrictions including supplementation of any kind are to be done at my own risk. If I have any concerns or ill effects after the nutrition protocols or from the use of any supplements, I will call NWC immediately. All medical information given is strictly confidential.

Patient Name____ Birthdate ______________

Street Address ____

City, ____________________ State,______ Zip __________ Cell Phone________________ Work______________

Email____

Client Signature____ Date ______________

Nutritional Wellness Center

Nutrition Health History

Name____ Date _________________

Primary Concerns **Onset** **Interventions Tried**

1. ____
2. ____
3. ____
4. ____
5. ____

Current Supplements ____

Current Medications ____

Vegetarian? Y | N Type ___________________________ Metal in your body (fillings, staples, pins, etc)? Y | N ___________________________

Allergies? Y | N Details____Surgeries? Y | N

Details _________________ History of Body or Head Trauma/Concussion? Y | N Details ____

___ Hospitalizations (exclude surgeries)? Y | N Details ____ Family History of Disease (Diabetes, Heart Disease, Cancer, etc.) ________________________ Height ______ Weight _________________ Blood Type ___________________

Occupation ______________ Industry _________

If you have any of the following, indicate **C** for a current condition and **P** for a past problem

____ Ulcer
____ Hiatal Hernia
____ Food Intolerance: Type: _______________
____ Chrons | Colitis | IBS
____ Asthma
____ URI Bronchitis_______times
____ Pneumonia
____ Emphysema
____ Ear Infections_______times
____ Strep Throat________times
____ Staph Infection | MRSA
____ Mononucleosis
____ Measles | Mumps
____ Autoimmune Disease
Type:____________________________
____ Diabetes Type: ____________________
____ Low Thyroid
____ Neurological Problem(s)
Type: ____________________________
____ Cancer Type: ______________________
____ Vertigo | Dizziness
____ Learning Disability
____ Addiction Type: ____________________
____ Eating Disorder
____ Eye Problems
____ Near-Sighted | Far-Sighted
____ Sleep Apnia | CPAP Use
____ Insomnia

____ Osteoporosis | Osteopenia
____ Arthritis Location: __________________
____ Gout
____ Psoriasis/Eczema
____ Varicose/Spider Veins
____ Heart issues
____ High/Low Blood Pressure
____ High Cholesterol
____ Stroke
____ Incontinence
____ Kidney Stones
____ STD Type: _________________________

Male Only
____ Infertility
____ Benign Prostatic Hyperplasia
____ PSA #____________________________

Female Only
____ Birth Control Type: _________________
____ Infertility
____ Endometriosis
____ Fibrocystic Breast
____ Uterine Fibroids
____ Ovarian Cysts
____ Yeast Infection
____ PID Pelvic Inflammatory Disease
____ History of Abnormal Pap
____ Menopause

____ PCOS
____ Pregnant? Y | N_________weeks
____ Trying to be Pregnant? Y | N
____ Number of Live Births
____ Pregnancies

Travel History
____ Mexico
____ Central/South America
____ India/Southeast Asia
____ Africa
____ Other _______________

Other Conditions

____

____

Please fill out completely

Stress: Scale 1-10 ___
Water:___oz/day
Juice:___glasses/day
Coffee:__cups/day Soda:
________times/week
Alcohol:_glasses/week
Tobacco:_times/day Soy
Use:____times/week
Equal (Aspartame):_times/week
Splenda (Sucralose):____times/week
Cardio Exercise:____times/week
Weight Training:__times/week
Yoga/Pilates:____times/week
Sports:____hours/week

****Please fill out completely: Rate any symptoms you are currently having: 1=Mild 2=Moderate 3=Severe ***

EARS
____ Noise (Ring/Hiss/Pound)
____ Plugged
____ Popping
____ Ache | Infection
____ Draining
____ Itchy
____ Hearing Loss
____ Dizziness | Vertigo
____ Excessive Ear Wax
____ Other ________________
____

EYES
____ Burn | Tear | Itchy
____ Ache | Dry | Red
____ Crust in a.m. | Film
____ Bouts of Blurriness
____ Floaters | Spots
____ Tired | Puffy
____ Stye
____ Twitching Around Eye
____ Dark Circles
____ Light Sensitive

SINUS
____ Nosebleeds
____ Dry
____ Drain
____ Stuffy | Plugged
____ Sneeze Frequently
____ Taste | Smell Loss
____ Post Nasal Drip
____ Color

STOMACH
____ Heartburn
____ Indigestion
____ Stomach
____ Ache | Cramps
____ Nausea | Vomiting
____ Bloat After Eat
____ Gas | Flatulence
____ Belching
____ Ulcer

CHEST
____ Tension
____ Tight
____ Pressure
____ Heaviness
____ Congestion
____ Chest | Sternal Pain
____ Palpitations
____ Heart Skip
____ Heart
____ Racing | Slowing

RESPIRATORY
____ Short of Breath Constant
____ Short of Breath Exertion
____ Wheeze
____ Air Hunger | Yawn
____ Frequent sighs
____ Upper Respiratory Infection
____ Asthma

BOWELS
____ Movements ____ per Week
____ Diarrhea
____ Constipation
____ Incomplete
____ Bulky
____ Cramps in Abdomen
____ Pain w/Bowel Movement
____ Laxative | Suppository Use
____ Colonics | Enemas
____ Anal Itching
____ Hemorrhoids
____ Swollen
____ Achy
____ Burning/Itchy
____ Blood

SLEEP
____ Hours in Bed
____ Hours Asleep
____ Quality of Sleep
Poor | Fair | Good | Great
____ Difficulty Falling Asleep
____ Difficulty Staying Asleep
____ Interrupted ____per Night
____ Waking at _____ a.m.
____ Crave Sleep During Day
____ Awaken Suddenly (Jolt)
____ Don't Dream
____ Nightmares | Epic dreams
____ Night Sweats
____ Restlessness
____ Restless Leg Syndrome

F E C A L
CONSISTENCY ____
Normal
____ Light Colored Feces
____ Soft
____ Hard
____ Pebbles
____ Ribbon-like
____ Mucous
____ Contain string-like
____ Black/White Specks
____ Contains Undigested Food

MEMORY
____ Forget Names/Numbers
____ Forget Words
____ Forget Actions
____ Difficulty Concentrating

EMOTIONS
____ Sadness | Depression
____ Moodiness
____ Irritable
____ Frustrated | Angry
____ Nervous | Anxiety
____ Grief
____ Panic | Fear
____ Cry
____ S.A.D.
____ OCD
____ Other ________________
____

APPETITE/DIET
____ Low/Norm/High Appetite
____ Crave Starch | Sweets
____ Crave Chocolate | Ice Cream
____ Eat Lots of Spicy Foods
____ Nighttime Snack
If Meals are Missed:
____ Nausea
____ Extreme Hunger
____ Cold/ Clammy
____ Rapid Heartbeat
____ Moodiness

HEADACHES
____ Base of Skull (Back)
____ Side of Head (Temples)
____ Frontal (Above Eyes)
____ Top of Head
____ Entire Head
____ Migraines

LIBIDO
____ Low | Normal | High

ENERGY
____ Normal/Low/Variable/High
____ Slow to Start in a.m.
____ Low Energy After Meals
____ Energy Crash at
_____ a.m./p.m.

URINATION
____ Times During the Night ____
____ Urgency
____ Burning
____ Pain
____ Odor
____ Dark Color
____ Foamy
____ Incontinence
____ Urinary Tract Infection
____ Kidney Troubles

MALE ONLY
____ Erectile Dysfunction
____ Prostate Problems
____ Burning
____ Achy | Pain
____ Restriction
____ Emission
____ Swelling

FEMALE ONLY
____ Date Last Period_________
____ Cycle - Length (28-30 days):
____ # Days of Flow
____ Heavy Flow
____ Large Clots
____ Cramps
(Mild | Mod | Severe)
____ PMS (Mild | Mod | Severe)
____ Yeast Infection
____ Menopause
____ Hot Flashes
____ Other ________________
____

SKIN/HAIR/NAILS
____ Skin Rash
____ Butt Acne
____ Dry Skin
____ Eczema
____ Psoriasis
____ Nails (White Spots/Ridges)
____ Nails (Weak/Peeling)
____ Hair Loss
____ Limp Hair
____ Varicose/Spider Veins
____ Damp Hands/Feet
____ Dandruff
____ Red Freckles
____ Bruise Easily
____ Missing Outer l/3 of Eyebrow
____ Cold Hands | Cold Feet

OTHER HEALTH EVENTS/ISSUES:
____
____
____
____
____
____
____
____
____
____

OFFICE USE ONLY	Iodine Patch:	Zinc:
pH:	WHR:	BMI:
Eyes:	Ears:	Tongue:
Skin:	Nails:	Weight:
Moist Sense:	BP:	Clinician Initials: