Nutritional Wellness Center

Integrative & Holistic Medicine for Optimal Health

New Patient Forms - Advanced Clinical Nutrition

Instructions for your First Appointment:

-Bring all medications, vitamins, minerals & supplements you are currently taking.

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

-**No** fasting required! Eat as you normally would prior to your appointment.

-**Important:** Please do not wear perfume or fragrances.

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

I, the client, choose to receive a nutrition status screening using muscle testing (Nutrition Response Testing & Autonomic Response Testing), Heart Rate Variability Testing, and/or Functional Medicine. The opinions received may include information on stress reduction, nutritional suggestions, including supplement or homeopathic remedies, and lifestyle changes.

I understand that NWC does not treat, diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. Appointments at NWC are provided to clients on a cash basis; NWC does not accept insurance and does 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 specialist for that type of service. I give consent to receive nutritional guidance on dietary changes and restrictions including supplementation. If I have any concerns or ill effects after a nutrition protocol 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_____

Alternate Phone#_____ 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 1/3 of Eyebrow
____ Cold Hands | Cold Feet

OTHER HEALTH EVENTS/ISSUES:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

OFFICE USE ONLY
pH:
Eyes:
Skin:
Moist Sense:

Iodine Patch:
WHR:
Ears:
Nails:
BP:

Zinc:
BMI:
Tongue:
Weight:
Clinician Initials: