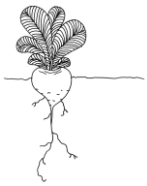

MARINA SILVERIO, RHN
Registered Holistic Nutritionist

Intake Forms

INSTRUCTIONS:
Please print these forms or request them from Marina Silverio, RHN. Please complete all pages as truthfully and completely as possible (the pediatric forms are only necessary for clients 12 and under). Filling out the Daily Food Log is very helpful. If you need extra space to answer any question, you can use the back of the form or a separate sheet of paper.

If you have any questions, you can email or phone me:

647-960-2853 or nutrition@marinaRHN.ca

Please provide completed forms to:

Marina Silverio, RHN
#305-32 Trolley Cres.
Toronto, ON
M5A 0E8

Client Information:

Name: _____

Date: _____

Date of Birth: _____

Daytime Phone: _____

Evening Phone: _____

Email: _____

COMPLETE LEFT SIDE OF FORM ONLY: If any of the following symptoms or activities have occurred *within the past three months* (unless otherwise specified), please indicate as follows:

1 *for mild or rarely occurring*
2 *for moderate or regularly occurring*
3 *for severe or often occurring*
Leave blank *if the symptom or statement does not apply*

Please complete this section		Right Side for Office Use Only	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
General fatigue or weakness												
Difficulty losing weight												
Frequent illness/infections												
High stress Lifestyle												
Smoking												
Drinking more than 2 cups of coffee/day												
Bad breath and/or body odour												
Constipation												
Bags under eyes												
Crave sugars, bread, alcohol												
Difficulty digesting certain foods												
Have used antibiotics in past 10 years												
Allergies												
Poor concentration or memory												
Belching or burping after meals												
Skin/complexion problems												
Frequent consumption of red meat												
Regular use of dairy products												
Heavy alcohol consumption												
Exposure to toxins/chemicals												
Frequent mood swings												
Depressed and/or irritable												
Brittle fingernails												
Dry, brittle hair, split ends												
High fat/high cholesterol diet												
Nervousness/anxiety/tension/worry												
Insomnia/restless sleep												
Low fibre diet												
Muscle cramps												
Sleepy when sitting up												
Female: menstrual cramps												
Bronchitis/asthma/pneumonia/emphysema												
Cellulite												
Cold hands and feet												
Varicose veins												
Feeling out of control												
Food/chemical sensitivities												
Frequent yeast/fungus problems												
Bones break easily, osteoporosis												
Too little exercise												
SCORES SUBTOTAL												

Please complete this section		Right Side for Office Use Only	1	2	3	4	5	6	7	8	9	10
SUBTOTALS												
Excessive mucous												
Short of breath climbing stairs												
Tingling in lips, fingers, arms, legs												
Chest pains												
Very rapid or slow heart beat												
Painful, hard or thin bowel movements												
Alternating constipation/diarrhea												
Recurrent bladder infections												
Female: Menopause, hot flashes												
Female: PMS												
Difficult urination												
Swollen glands, puffy throat												
Lower abdominal pain												
Frequent need to urinate												
Joint pain												
Sinus inflammation/discharge												
Arthritis												
Sudden weight gain/loss												
Headaches/Migraines												
Female: Taking birth control pills												
Lower back pains												
Dry, flaky skin												
Drink less than 6 glasses of fluids/day												
Water retention												
Low sex drive												
Feeling heavy/bloated after meals												
Chronic cough												
SCORES TOTAL												

For Office Use Only: please skip to the top of the next page.

SYSTEMS RATING TABLE:

1.	Digestive	
2.	Intestinal	
3.	Circulatory/Cardiovascular	
4.	Nervous	
5.	Immune/Lymphatic	
6.	Respiratory	
7.	Urinary	
8.	Glandular/Endocrine	
9.	Structural	
10.	Reproductive	

COMMENTS:

GENERAL QUESTIONS:

What are your main health concerns?

Have you been diagnosed with any health conditions?

In your own words what do you consider to be healthy foods?

In your own words, how healthy do you think you are?

How do you think your health condition, if it stays as is, will impact your health?

On a scale of 1-5, how concerned are you about your health issues?

(not concerned) 1 2 3 4 5 (extremely concerned)

Have you made any lifestyle changes (diet, exercise etc.) to help with your health concern?

If so, list any changes:

If you change nothing about your lifestyle where would you see yourself in 5 years?

Regarding food and lifestyle, are there any changes that you haven't made but believe you should?

Regarding food and lifestyle, is there anything you believe you have tried to or should try to avoid?

What obstacles or challenges are you experiencing when making food and lifestyle changes?

Describe what goals would you like to achieve by the next 3 months?

By 6 months?

By 1 year?

PRODUCTIVITY QUESTIONS:

The following questions ask about the effect of your health problems (i.e. any physical or emotional problem or symptom) on your ability to work and perform regular activities, as well as your quality of life.

If you worked you full work week, hour many hours would that be? _____ hours

During the past 7 days (not including today), how many hours did you miss from work because of your health problems? (Include hours you missed from sick days, times you went in late, left early, etc. because of your health problems). _____ hours

During the past 7 days (not including today), how many hours did you miss from work because of any other reason, such as vacation, holidays, etc.? _____ hours

In the following questions, rate how much your health problems affected your productivity while you were working:

During the past 7 days (not including today), how much did health problems affect your productivity by limiting the kind of work you can do:

(no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely prevented the kind of work)

During the past 7 days (not including today), how much did your health problems prevent you from accomplishing your tasks?
(accomplished all tasks) 0 1 2 3 4 5 6 7 8 9 10 (accomplished no tasks)

During the past 7 days (not including today), how much did your health problems prevent you from doing your work as carefully as usual?
(no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely prevented carefulness)

During the past 7 days (not including today), how much did your health problems affect your ability to do your regular activities, other than work at a job? (the usual activities you do, such as work around the house, shopping, childcare, exercising, studying, etc.)
(no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely prevented from daily activities)

During the past 7 days (not including today), how did your health problems affect your relationships at work with any of: co-workers, employers, customers and/or clients
(no effect) 0 1 2 3 4 5 6 7 8 9 10 (significant effect)

In what ways have your health problems affected your quality of life (eg. do you choose to avoid social activities, does it affect relationships, does it affect things you would normally want to do, or how you normally feel)?
(no effect) 0 1 2 3 4 5 6 7 8 9 10 (significant effect)

Describe what your ideal quality of life would be (describe what you would be doing and feeling):

GENERAL LIFESTYLE QUESTIONS:

How would you describe your current level of stress? (*minimal) 1 2 3 4 5 (unbearable)*

What are the major causes of stress your stress? (Circle all that apply)

Health	*Personal*	*School*	*Family*
Financial	*Career*	*Marriage*	*Spiritual*
Unfulfilled expectations		*Other (please elaborate):*	

How does your stress manifest itself? (E.g., headaches, sleeplessness, biting nails, anger, irritability etc…)

Do you use any coping mechanisms for stress? Circle one: *always often sometimes rarely never*

Please list any coping mechanisms you will use (E.g., napping, smoking, certain types of physical activity, music, meditation, alcohol etc…):

Have you experienced any trauma or loss in the past 5 years? Explain:

How many hours on average do you sleep daily? Circle one: *3-5 6-7 8-9 10 or more*

Do you have any naps during the day?
How long does it take you to fall asleep?
Do you awaken feeling rested? Circle one: *always often sometimes rarely never*
Is your sleep often disrupted? Circle one: *always often sometimes rarely never*
How do you help yourself fall asleep or fall back asleep?

Do you smoke? Circle one: *always often sometimes rarely never*
Does anyone in your household or workplace smoke? Circle one: *always often sometimes rarely never*

Do you exercise? Circle one: *6-7x/week 4-5x/week 2-3x/week 1x/week less than 1x/week never*

On average, indicate the type and length of physical activity you do:

Yoga:
Walking:
Running:
Stretching:
Weight training:
Other:

Do you wish to gain weight? Lose weight? If so, how much?

On an average day, how many hours do you spend doing the following:
driving: watching television: reading: on the computer:

What type of work do you do?
Do you enjoy your work?
How many hours each day do you work?
Do you do shift work.? If yes, how often?

MEDICAL HISTORY:

Have you ever been:
Diagnosed with an illness or condition? Explain:

Hospitalized? Reason:

List any medications you are currently taking with the reason, the dosage, and since how long:
Ones recommended by a doctor:

Any over the counter medications? (aspirin, ibuprofen, Tylenol, allergy medicines, antacids etc.):

Are you currently seeing (or have you seen in the past) any of the following (circle all that apply):

Naturopath	Chiropractor
Homeopath	Osteopath
Holistic Nutritionist	Dietician
Massage Therapist	Energy Therapist

List any vitamins, minerals, herbal or homeopathic remedies you are currently taking (with the amounts/dosages):
Are these taken on a regular basis, or sporadically?

Do you have any known allergies (environmental or food)? If so, please list:

Are you aware of any food sensitivities?

How often do you have bowel movements? Circle one: *3 or more/day 2/day 1/day 3-4/week 1-2/week or less*
Do you strain to have a bowel movement? Circle one: *always often sometimes rarely never*
Related to particular food or circumstance?
Do you have loose bowel movements? Circle one: *always often sometimes rarely never*
Related to particular food or circumstance?

Have you ever been treated for drug and/or alcohol dependency?
Please indicate for what:

Please indicate any of the following Diseases for yourself or other family members:
Use "S" for self, "F" for father, "M" for mother, "G" for grandparent, "O" for others:

Heart Disease:	High Blood Pressure:	High Cholesterol:
Diabetes Type 1:	Diabetes Type 2:	Allergies:
Arthritis:	Osteoporosis:	Intestinal Disease:
Cancer:	Mental Illness:	
Other (please list):		

FEMALES:

Are you pre-menopausal or menopausal?
Are you experiencing any symptoms?
If yes, please specify: (eg/sudden surges of heat, mood swings, sporadic periods etc…)

Have you had a bone density test?
If yes, what was the result?

DIETARY HABITS:

How many times a day do you eat (circle):
Main Meals: 0 1 2 3 4 5 Times of day:
Snacks: 0 1 2 3 4 5 Times of day:

Do you plan the frequency and timing of your meals carefully? Circle one: *always often sometimes rarely never*

How often do you eat your meals…:

In the car:	*always*	*often*	*sometimes*	*rarely*	*never*
In front of the computer at work:	*always*	*often*	*sometimes*	*rarely*	*never*
With family:	*always*	*often*	*sometimes*	*rarely*	*never*
Home alone:	*always*	*often*	*sometimes*	*rarely*	*never*
On the run:	*always*	*often*	*sometimes*	*rarely*	*never*
At sit down restaurants:	*always*	*often*	*sometimes*	*rarely*	*never*
At fast food chains:	*always*	*often*	*sometimes*	*rarely*	*never*

Do you feel there are restrictions to your diet due to preferences of others? (family, roommates, etc.)
Circle one: *always often sometimes rarely never*
If yes, explain:

Are you a: vegetarian? Y N vegan? Y N
If you are a meat eater, how often do you eat meat? Circle one: *daily 3-5/week once/week or less*
What types of meat do you eat?
If applicable, how often do you eat fish? Circle one: *daily 3-5/week once/week or less*
What types of fish do you eat?

How often do you consume dairy products? (milk, yogurt, cheeses, sour cream, ice cream, etc.)
Circle one: *daily 3-5/week once/week or less*
Indicate types of dairy products you eat:

What are your favourite foods?
How often do you eat them?

Do you dislike or avoid certain foods?
If yes, which foods and why?

Do you experience any symptoms if meals are missed? Explain:

Do you experience any symptoms after meals? Explain:

How many servings of each of the following do you typically eat in a day?
Fruit: (E.g., 1 serving = 1 medium size fruit or ½ cup fruit)
Fresh: *0 1 2 3 4 5*
Dried: *0 1 2 3 4 5*
Canned: *0 1 2 3 4 5*

Vegetables: (eg/ 1 serving = ½ cup of vegetables or 1 cup of salad)
Cooked: *0 1 2 3 4 5*
Raw: *0 1 2 3 4 5*
Whole Grains: (eg/ 1 serving = 1 slice bread, ½ cup rice or pasta)
0 1 2 3 4 5
Vegetable Proteins: (eg/ 1 serving = 1 cup of beans, 2 tsp. of peanut butter, or ¾ cup of tofu)
0 1 2 3 4 5
Animal Proteins: (eg/ 1 serving = a palm size piece of meat or fish, or 1 egg)
Any: *0 1 2 3 4 5*
Dairy Products: *0 1 2 3 4 5*
Other foods (please specify):

What fats/oils do you cook with?

What foods containing fats do you regularly consume? (e.g., nuts, meats) – be specific:

How often do you eat or use:

Microwave:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Margarine:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Luncheon meats:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Candy:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Chocolate:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Breath Mints:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Gum with sugar:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Gum (sugarless):	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Refined foods (white flour/sugar):	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
White rice/pasta:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/*day
Fried foods:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Fast foods:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Nutra-Sweet/Aspartame:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Splenda/Sucralose:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*
Stevia:	*never*	*monthly*	*biweekly*	*weekly*	*daily*	*2+ times/day*

I am aware of my water intake and am conscious of staying hydrated throughout the day:
Circle one: *always often sometimes rarely never*

How many (8 oz/250mL) cups of fluid would you drink with your average meal?
Circle one: *¼ ½ ¾ 1 1 ½ 2+*

Please indicate how many (8 oz/250mL) cups of the following you drink per day:

Bottled/spring water:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
tap water:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
coffee:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
tea:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
herbal tea:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
milk (1% or 2%):	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
milk (skim):	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
prepared fruit juices:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
fresh fruit juices:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
fresh vegetable juices:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
soft drinks (regular):	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
soft drinks (diet):	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
beer:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
red wine:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
white win:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
other alcoholic beverages:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
other (list):	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

Any further Comments:

THE INTESTINAL SYSTEM

If any of the following symptoms or activities apply please indicate by checking:

1 - for mild or rarely occurring
2 - for moderate or regularly occurring
3 - for severe or often occurring
or leave blank - if the symptom/statement does not apply.

Extreme fatigue	
Recurrent vaginal infections	
Frequent use of antibiotics	
White coated tongue, oral thrush	
Crave sugars, bread, alcohol	
Headaches	
Tonsillitis, recurrent strep throat	
Itchy, watery or dry eyes	
Skin flushes	
Chronic indigestion, frequently use antacids	
Always cold, especially in extremities	
F: PMS	
Pain in pelvic area	
Abdominal gas and bloating	
Loss of sex drive	
Cystitis, repeated bladder infection	
Increasing food and chemical sensitivities; severe reaction to tobacco, perfume, etc	
F: endometriosis / ovary problems	
Chronic diarrhea	
Hives, psoriasis, acne, skin rashes	
Rectal itching	
Abnormal muscle aches from exercise	
Excessive wax in ears	
Unexpected / unexplained weight gain	
Impotence	
Canker sores	
Athlete's foot, finger / toenail fungus, ringworm	
Jock itch	
"Brain fog"	
Irritability	

Memory loss	
Mental confusion	
Depression or anger for no reason	
Anxiety / panic attacks	
Inability to concentrate	
Phobic / compulsive	
Lethargy	
Mood swings	
Itchy ears, nose, anus	

Forgetfulness	
Slow reflexes	
Gas and bloating	
Unclear thinking	
Loss of appetite	
Yellowish or pale face	
Fast heartbeat	
Heart pain	
Pain in navel	
Eating more than normal but still feeling hungry	
Blurry or unclear vision	
Pain in the back, thighs, shoulders	
Numb hands	
Drooling while sleeping	
Damp lips at night	
Dry lips during the day	
Grind teeth while asleep	
Bedwetting	
Lethargy; chronic fatigue	
Dark circles under eyes	
Cancer	

THE DIGESTIVE SYSTEM

If any of the following symptoms or activities apply please indicate by checking:

1 - for mild or rarely occurring
2 - for moderate or regularly occurring
3 - for severe or often occurring
or leave blank - if the symptom/statement does not apply.

Excessive gas, belching or burping after meals	
Stomach bloated after eating	
Sleepy after eating	
Longitudinal striations on fingernails	
Eat when rushed or in a hurry	
Halitosis (bad breath)	
Full feeling after a heavy meat meal	
Heavy, tired feeling after eating	
Nausea after taking supplements	
Acne	
Undigested food in the stool	

Yellow or pale fingernails	
Oily skin on nose or forehead	
Fats/greasy foods cause nausea / headaches	
Vertical white streaks on fingernails	
Onions, cabbage, radishes, cucumbers cause bloating / gas	
Bad breath; bad taste in the mouth	
Excess body odour	
High cholesterol / high cholesterol diet	
Stiff, aching muscles	
Migraine headaches	
Discomfort underneath right ribcage	
Food allergies	
Irritable, loose temper easily	
Weight gain around the abdomen	
Yellow palms	
Jaundice	
Poor concentration	
Difficulty losing weight	
Acne, boils, rashes, psoriasis or eczema	
Constipation	

Gallstones; history of gallstones	
Stool appears clay coloured, foul odoured	
Constipation	

High blood cholesterol levels / diet	
Severe pain in right upper abdomen	

Stomach pain 1 hour after eating / at night	
Burning sensation in stomach	
Pain aggravated by worry / tension	
Hiatal hernia	
Gastritis, gastric ulcer	
Nausea, vomiting	
Sensation of acidity in abdominal area	
Heartburn, indigestion	
Blood in stool	
Lower back pain	
Long term aspirin use	

Severe abdominal pain	
Nausea and vomiting	
Slow digestion: feel full hours after eating	
Fever	
Alcohol addiction	
Jaundice	

Hungry up to 3 hours after eating	
Strong sudden cravings for sweets, starches, coffee or alcohol	
Nervous/anxious feelings relieved by eating	
Irritable if late for, or skip a meal	
Overweight	
Addicted to coffee with sugar and/or colas	
Frequent midnight snacks	
Family history of diabetes	
Fatigue	
Frequent headaches	
Fainting spells	
Depression	
Lose temper easily	

THE GLANDULAR & ENDOCRINE SYSTEM

If any of the following symptoms or activities apply please indicate by checking:

1 - for mild or rarely occurring
2 - for moderate or regularly occurring
3 - for severe or often occurring
or leave blank - if the symptom/statement does not apply.

Distinct, lethargic tiredness or sluggishness	
Cold hands or feet	
Mercury amalgams (fillings)	
Gain weight easily, fail to lose on diets	
Constipation, less than one bowel movement a day	
Low energy in the morning	
Low pulse rate	
Low body temperature, especially at bed rest	
Hair dry, brittle, dull, lifeless	
Flaky, dry rough skin	
Feel stiff after sitting still for some time	
Mood swings	
Unusually square and wide fingernails	
High cholesterol	
Diminished sex drive	

Infertility or impotence	
Headaches affecting one side of head	
F: loss of menstrual function	
Moody	
Overweight from waist down	
Overweight from waist up	
Excessive urination	
Pain in little finger of left hand	
Swelling in ankles, fingers, feet	
Cold hands or feet	
Pain in left side of upper neck	

Losing weight without trying	
Heart races while at rest	
Feel warm / flushed at room temperature	
Hands shake or tremble	
Protruding tongue	
Heart palpitations	
Nervous behaviour, hyperactivity	
Insomnia	
Increased appetite	
Frequent bowel movements, diarrhea	
Excessive sweating without exercising	

Stress or emotional upsets cause exhaustion	
Blood pressure decreases when going from a lying position to a standing position	
Perspire excessively	
Neck and/or shoulder tension	
Frequent headaches	
Bow lines (depressed furrows) on fingernails	
Occasional cold sweats	
Tightness or lump in throat, especially when emotionally disturbed	
High or low blood pressure	
Rapid pulse	
Short temper	
Puffy face	

THE LYMPHATIC & IMMUNE SYSTEMS

If any of the following symptoms or activities apply please indicate by checking:

1 - for mild or rarely occurring
2 - for moderate or regularly occurring
3 - for severe or often occurring
or leave blank - if the symptom/statement does not apply.

194	Excessive sleep	
195	Very susceptible to infections	
196	Swollen glands: tonsils, throat, armpits	
197	History of cancer, MS, Parkinson's, arthritis	
198	Loss of appetite	
199	Headaches	
200	Soreness on both sides of neck at shoulder	
201	Feel puffiness in throat	
202	Look older than chronological age	
203	Flu-like symptoms often occur	
204	Lupus	

205	Acne, psoriasis, dermatitis, eczema	
206	Rapid pulse, heart irregularities	
207	Frequent headaches	
208	Hay fever	
209	Frequent cravings for certain foods	
210	Periods of blurred vision	
211	Repeated ear trouble	
212	Hyperactivity	

213	Dizzy spells	
214	Periods of confusion	
215	Poor concentration	
216	Epilepsy	
217	Muscle cramps or spasms	
218	Abnormal body odour	
219	Excessive sweating, night sweats	
220	Bowel disease: IBS, IBD, Crohn's etc.	
221	Joint pains or stiffness	
222	Frequent night urination	
223	Wheezing	
224	Pale face	
225	Hives	
226	Nose runs constantly	
227	Noticeable changes in writing throughout the day	
228	Nosebleeds	
229	Bloating or gas after eating certain foods	
230	Canker sores	
231	Dark circles under eyes	
232	Stuffy nose	

THE STRUCTURAL-MUSCULAR / SKELETAL SYSTEM

If any of the following symptoms or activities apply please indicate by checking:

1 - for mild or rarely occurring
2 - for moderate or regularly occurring
3 - for severe or often occurring
or leave blank - if the symptom/statement does not apply.

Pain, swelling, stiffness in joints	
Joint inflammation (rheumatoid arthritis)	
Pain, stiffness, inflammation of spine	
Facial pain	
Joints make popping sounds	
Gout	
Joints make sounds like crinkling cellophane	
Ankylosing spondylitis	
Bones fracture easily	
Gradual loss of height	
Tooth loss; teeth “falling out”	
Lack of exercise	
Rounding of shoulders; stooping	
F: Menopause	
Pain in forearm or biceps	
Cramps in calf muscle during sleep or exercise	
Painful cramping of feet or toes	
Teeth prone to decay, frequent toothaches	
Malformation of bones	
Insomnia	
Muscles weak, weak grip, light objects feel heavy	
Heart palpitations	
Diet high in animal foods (meat, dairy, eggs)	

Muscle pain	
Muscle weakness	
Sprains; muscle strains	
Muscle(s) spasm	

Muscles wasting in some part of the body	
Numbness or loss of sensation	
Mood swings and/or depression	
Blurred or double vision	
Tingling and/or numbness, especially in	
extremities	
Muscular stiffness	
Difficulty breathing	
M: impotence	
Tremors	
Loss of peripheral vision	
Slurred speech	
Objects fall from hands, reach in wrong place	
Hands tremble	
Impaired speech	

DAILY FOOD LOG

DAY	BREAKFAST	LUNCH	DINNER	SNACKS
SUN				
MON				
TUE				
WED				
THU				
FRI				
SAT				

PEDIATRIC FORM

To be used for children 12 years of age or under, and in conjunction with all other forms.

SYMPTOMS: (mark C for current and P for past symptoms)

____ Abdominal pain	____ Excessive fatigue	____ Nightmares
____ Acid reflux	____ Excessive perspiration	____ Night sweats
____ Anemia	____ Flat feet	____ No appetite
____ Bad breath	____ Frequent headaches	____ Nosebleeds
____ Bed wetting	____ Gas	____ Painful urination
____ Bleeding gums	____ Hearing loss	____ Parasites
____ Blood in urine	____ Heart murmur	____ Psoriasis
____ Body odour	____ High fevers	____ Rash
____ Bruises easily	____ Hives	____ Sensitive to light
____ Canker sores	____ Hyperactivity	____ Sleep problems
____ Changes in appetite	____ Itchy anus	____ Stomach aches
____ Congestion	____ Itchy nose (or picks nose)	____ Sore throat
____ Constipation	____ Itchy vagina	____ Teeth grinding
____ Cough	____ Jaundice	____ Talks in sleep
____ Cries easily	____ Joint pains	____ Walks in sleep
____ Diarrhea	____ Migraines	____ Weight gain
____ Dizzy spells	____ Motion sickness	____ Weight loss
____ Dry Skin	____ Nervousness	____ Wheezing
____ Eczema		____ Vomiting spells

For Office Use Only:

MEDICAL HISTORY: (check all that apply)

❒ ADD/ADHD	❒ Dental problems	❒ Neural Tube Defect
❒ Allergies (environmental)	❒ Developmental problems	❒ Pneumonia
❒ Allergies (food)	❒ Ear infections	❒ Rubella
❒ Asthma	❒ Frequent colds	❒ Rheumatic Fever
❒ Autism	❒ Impaired speech	❒ Scarlet Fever
❒ Bronchitis	❒ Measles	❒ Tonsillitis
❒ Chicken Pox	❒ Meningitis	❒ Whooping cough
❒ Croup	❒ Mumps	❒ Other (specify):

Nutritional Supplements (please list). Include herbal and homeopathic as well.

For Office Use Only:

MEDICATIONS. (check all that apply, and indicate the length of time the child received each medication.

❒ Antacids	❒ Declectin	❒ Methylphenidate (Ritalin)
❒ Antibiotics	❒ Decongestant	❒ Oral Steroids
❒ Antidepressants	❒ Dextroamphetamine (Dexedrine, Dextrostat, Adderall)	❒ Pemoline (Cylert)
❒ Anti-Histamine	❒ Epilepsy medication	❒ Tylenol
❒ Aspirin	❒ Ibuprofen	❒ Others (please list)
❒ Clonidine	❒ Inhaled Steroids	❒

Are you aware of any allergies to medications?

IMMUNIZATIONS: (check all that apply)

❒ Diptheria	❒ Influenza	❒ IPV (Polio)
❒ DPT	❒ Measles	❒ PNEU (Pneumoccocal disease)
❒ Hemophilus	❒ MENI (Menigococcal disease)	❒ Small pox
❒ Hepatitis	❒ MMR (Measles, Mumps, Rubella)	❒ Tetanus
❒ Hib (Hemophilus Influenza)	❒ Mumps	❒ VAR (Varicella or chicken pox)

Were there any reactions to immunization(s)? If so, at what age?

MOTHER'S HEALTH DURING PREGNANCY: (check all that apply)

❒ Alcohol, Cigarettes, Drug Consumption	❒ Gestational Diabetes	❒ Stress
❒ Anemia	❒ Hypertension	❒ Thyroid problems
❒ Bleeding	❒ Nausea	❒ Uterine infection
❒ Dental problems	❒ Physical or Emotional Trauma	❒ Other (specify):
❒ Diabetes	❒ Pre-eclampsia	

For Office Use Only:

MEDICATIONS WHILE PREGNANT:

MEDICATIONS WHILE NURSING (Mother):

TERM:
Full ____ Premature ____ Late ____
Weight at birth _____ lb

LABOR & DELIVERY:
Was pregnancy induced? _____
Vaginal _____ C-Section _____ Complications during labor? _____
Medications during or after labor? _____

FEEDING:
Breast fed _____ Bottle fed _____
When was formula started? _____
When were solid foods first introduced? _____
What were the first foods introduced? _____
_____

Did your baby have any of the following problems?
____ Jaundice
____ "Blue Baby"
____ Colic
____ Diarrhea
____ Thrush