Nutrition and Integrative Health Adult Questionnaire

Instructions for your first nutrition consultation

Thank you for taking the time to thoughtfully answer the questions in this new client questionnaire. You'll have ample opportunity to address any concerns that require more detail during your appointment.

Required for your first visit:

1. The completed new client questionnaire, along with the 3-Day Diet Diary included in the questionnaire.

   Instructions for completing the 3-Day Diet Diary:

   - Record information as soon as possible after the food has been consumed. Please include all beverages, even water.
   - Do not change your eating behavior at this time unless your doctor advises you to. The purpose of this food record is to analyze your present eating habits.
   - Describe the food or beverage consumed. e.g., milk - what kind? (whole, 2%, or nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
   - Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
   - Include any additional items (i.e. condiments). For example: tea with 1teaspoon sugar, potato with 2 teaspoons butter, etc.

2. prior to your visit, Please send this intake form and any any labs, blood tests or other pertinent medical information you think may be helpful to:
   Jennifer@TheMindfulHeartLLC.com

Please bring the following:

- Any pharmaceuticals, over-the-counter drugs, and/or supplements you are taking – please bring them in their <u>original containers</u> for review

3. **If you have any questions please contact us: Jennifer@TheMindfulHeartLLC.com**

NUTRITION

Adult Questionnaire

Please allow 30-45 minutes to complete most of this questionnaire. The 3-day diet diary will require you to record your food and beverage intake over a 3-day period. Please answer the questions below as thoroughly as possible so that we may make the best possible clinical assessment. This helps us develop a realistic and workable plan for supporting you in reaching your health goals. Your answers to personal questions such as relationship status, religion, etc. are important as they provide helpful context for establishing a productive partnership with you. That said; please answer only the questions you are comfortable answering.

Basic Information

Primary Physician's Name: Physician Office Number:

Physician Address: Physician Fax Number:

Today's Date:

Contact Information			
Name:		Address:	
Work phone:		Home phone:	
Mobile phone:		Email:	
Preferred contact method:		Best time(s) of day to reach you:	

Emergency Contact					
Name:		Relationship:		Phone:	

Occupation & Interests					
Occupation:		How long?		Satisfied? (1-10)	
What are your interests/passions:					

Demographics									
Age		Date of Birth		Gender		Race		Ethnicity	
Height:		Weight	lbs.	Highest Adult Weight	lbs. / Yr.:		Lowest Adult Weight		lbs. / Yr.:

Relationship Information					
Status		Partner's Name:			

Personal Information			
Religion:		Education:	

With whom (persons or animals) do you share your home?	

What types of health practitioners are you currently working with?

What are your primary reasons for seeking nutrition and integrative health services?

1.

2.

3.

Medical Information

What health concerns did you experience as a child?

What health concerns have you experienced as an adult?

Has your doctor diagnosed you with a medical condition (s)? If so, please list:

Are you part of a recovery program? If so, which one?

Do you have any allergies to foods, medications, chemicals, and/or other environmental substances?
If so, to which ones?

What is your typical reaction and how severe is it (1-10)?

What, if any, surgeries/operations have you undergone, and when?

Have you ever been hospitalized for reasons other than surgeries/operations?
If so, when and for what reason(s)?

Have you ever had a major chemical exposure? If so, when and to what?

Where and when have you lived or traveled outside of the U.S. and Canada?

Is there anything that surfaced during a recent medical test, lab work, or doctor's visit that you would like to report?

Family History

Relationship	Alive/Deceased	Present Health or Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brothers		
Sisters		

Children/ages		

Medications & Supplements

Current Medications (Over-the-Counter and Prescription)				
Name	Dosage	Frequency	Length of Time	Reason for Taking
What medication have you taken in the past for a considerable amount of time?				

Current Dietary or Herbal Supplements					
Name	Brand	Dosage	Frequency	Length of Time	Reason for Taking

For Women

Pregnancies *(please include losses/terminations)*			
Year	Vaginal/C Section	Sex	Complications/Other Things You Want to Mention

Are you currently pregnant? Are you actively trying to conceive?
Are you breastfeeding?

Physical Activity					
	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Active lifestyle					Examples?
Cardio type exercise					What type(s)?
Strength building exercise					What type(s)?
Stretching					What type(s)?
How would you categorize your activity level?	Sedentary	Mildly Active	Moderately Active	Very Active	Intensely Active

Sleep	
At what time are you typically in bed?	
What time do you fall asleep?	
Typical hours asleep?	
# of times you awaken during the night	

Reason(s) why you wake during the night	
Do you feel rested upon rising?	

Lifestyle

	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Sexual Activity					
Socializing w/Friends					
Relaxation/ Self Pampering					What type(s)?
Tobacco					What type(s)?
Recreational Drugs					What type(s)?
Teeth Flossing					

Stress

On a scale of 1-10, with 1 being low and 10 being high, how stressful is your:

Work:		Social/family situation:		Current health status:		Life in general:	

Do you feel that your current state of health is:	largely in your control or largely out of your control
What do you believe you can do to make a difference in your current health status?	
If so, what 1-2 key steps have you already taken?	

Moods You Experience Frequently

☐ accepting	☐ anxious or nervous	☐ angry	☐ capable	☐ compassionate
☐ determined	☐ dreadful	☐ empowered	☐ enthusiastic	☐ fortunate
☐ guilty	☐ happy	☐ hopeful	☐ hurt	☐ inspired
☐ lonely	☐ loved	☐ peaceful	☐ resentful	☐ resigned
☐ sad	☐ scared	☐ terrified	☐ tired	☐ uncertain

Significant Life Events

Please list major events in the last ten years of your life and the dates they occurred. Include illness, medical condition, births, deaths, marriage, divorce, accidents, moves, jobs changes, miscarriages, and anything else you feel greatly impacted your life.

Date	Event

Metabolic Screening Questionnaire

Use this questionnaire to chart your health and progress. Rate each of the following symptoms based on your health for the past thirty days.

Point Scale:
O = Never or almost never have the symptom.
1 = Occasionally have it; effect is not severe.
2 = Occasionally have it; effect is severe.
3 = Frequently have it; effect is not severe.
4 = Frequently have it; effect is severe.

The Medical Symptom Questionnaire was developed by Jeffrey Bland, PhD.

Digestive Tract
- Nausea or vomiting
- Diarrhea
- Constipation
- Bloated feeling
- Belching or passing gas
- Heartburn
- **Total**

Ears
- Itchy ears
- Earaches, ear infections
- Drainage from ear
- Ringing in ears, hearing loss
- **Total**

Emotions
- Mood swings
- Anxiety, fear, or nervousness
- Anger, irritability or aggressiveness
- **Total**

Energy/Activity
- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness
- **Total**

Eyes
- Watery or itchy eyes
- Swollen, reddened, or sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel vision
- Slurred speech
- **Total**

Mouth/Throat
- Chronic coughing
- Gagging, frequent need to clear throat
- Sore throat, hoarseness, loss of voice
- Swollen or discolored tongue, gums, lips
- Canker sores
- **Total**

Nose

Head
- Headaches
- Faintness
- Dizziness
- Insomnia
- **Total**

Heart
- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest Pain
- **Total**

Joints/Muscles
- Pain or aches in joints
- Arthritis
- Stiffness or limitation in movement
- Pain or aches in muscles
- Feeling of weakness or tiredness
- **Total**

Lungs
- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- **Total**

Mind
- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Difficulty in making decisions
- Stuttering or stammering
- Learning disabilities
- **Total**

Skin

Acne
- Hives, rashes, or dry skin
- Hair Loss
- Flushing or hot flashes
- Excessive sweating
- **Total**

Weight
- Binge eating/drinking

Other
- Frequent illness

Stuffy nose	Craving certain foods	Frequent or urgent urination
Sinus problems	Excessive weight	
Hay fever	Compulsive eating	Genital itch or discharge
Sneezing attacks	Water retention	
Excessive mucus formation	Underweight	
Total	**Total**	**Grand Total**

Symptom Questionnaire

Please place **yes or no** after each question.

Section 1	
Indigestion, burping, bloating or sleepy immediately after meals	
Heartburn or acid reflux symptoms	
Tendency to allergies, eczema, asthma	
Nausea in evenings	
Proteins hard to digest, complex meals hard to digest (combination of proteins and carbs)	
Loss of taste for meat	
Sense of excess fullness after meals	
Feel like skipping breakfast, overall low appetite	
Undigested food in stool	
Anemia, unresponsive to iron	

Section 2	
Heartburn or acid reflux symptoms	
Nausea in mornings	
Strong appetite, demanding hunger, excess salivation	
Aggravated by spice or sour, sour burps, sour smell	

Section 3	
Pain between shoulder blades	
Stomach upset by fatty or fried foods	
Loose stools with fatty foods, irregular stools, fat in stools (shiny, floating), smelly stools	
Nausea	
Light, clay colored or greenish/yellow stools	
Dry skin, itchy feet or skin peels on feet	
Gallbladder attacks	
Gallbladder removed	
Bitter taste in mouth, especially after meals	
Easily intoxicated or hung if you were to drink wine	
Pain under right side of rib cage	
Hemorrhoids or varicose veins	
Sensitive to chemicals (perfume, cleaning agents, etc.), diesel fumes or tobacco smoke	

Section 4	
Food allergies or sensitivities (wheat or grain, or dairy or other)	
Frequent intake of allergenic food (s), strong attachment to allergenic foods	
Craving, addiction or binging of allergenic foods (s)	
Abdominal bloating 1-2 hours after eating	
Pulse speeds up after eating	
Crohn's disease, frequent sinus infection, migraines, asthma	
Airborne allergies	
Experience hives	

Section 5	
Catch colds at the beginning of winter	
Frequent colds, flu or other infections (sinus, ear, bladder, skin, etc.)	

Experienced a mucous producing cough	
Never get sick	
History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis, or other chronic viral conditions	
Have food allergies or sensitivities	

Section 6	
Coating on your tongue	
Anus itches	
Fungus or yeast infections	
Yeast symptoms increase with sugar, starch or alcohol consumption	
Less than one bowel movement a day	
Constipation, stools hard or difficult to pass	
Excessive foul smelling lower bowel gas	
Irritable bowel or mucous colitis	
Bad breath or strong body odor	
Cramping in lower abdominal region	
Stools are difficult to pass	
History of parasites	
Stools have corners or edges, are flat and ribbon shaped	

Section 7	
Eat less than five servings of (one-half cup cooked, 1 cup raw) of colored vegetables or fruits a day	
Crave sweets, breads, rolls, cookies, pasta, pizza or chips	
Crave coffee or sugar in the afternoon	
Sleepy in the afternoon	
Fatigue is relieved by eating	
Binging or uncontrolled eating	
Excessive appetite	
When you eat snacks/sweets, do you eat them, get a temporary boost of energy and mood, and later crash?	
Headache, irritability or shakiness if meals are skipped or delayed	
Heart palpitations after eating sweets	
Have frequent thirst	
Have frequent urination	
Once you start eating sweets or carbohydrates, do you feel you can't stop	
Tend to gain weight in the belly	
Have pre-diabetes, diabetes, PCOS, hypoglycemia or alcoholism or a family history of any one of these	
Have elevated triglycerides or cholesterol	
Have high blood pressure	

Section 8	
Have high or low blood pressure	
Have a low libido	
Have trouble falling asleep	
Get less than 8 hours a sleep a night	
Go to bed frequently after midnight	
Get less than 1 hour a day of sunlight	
Work the night shift	
Are you an emotional eater	
Feel anxious or have panic attacks	
Are you a shallow breather	
Experience heart palpitations	
Cravings for salt or sweets	
Experience chronic or prolonged fatigue	

Does fatigue prevent you from doing things you would like to do. Interfere with you work, family or social life	
Do you feel you can't get started in the morning without coffee or caffeinated drinks	

Section 9	
Are you cold when everyone else is warm	
Have course or brittle hair	
Experience constipation	
Have thinning hair or hair loss	
Experienced a loss of sex drive	
Lost the outside of your eyebrow	
Experience depression	
Have trouble losing weight	
Have a low blood pressure or heart rate	
Have elevated cholesterol	
Have a hoarse voice	
Have dry, scaly skin	
Have cold hands and feet	
Experience fatigue	
Experience fluid retention	

Section 10	
Aware of irregular or heavy breathing	
Experienced discomfort at high altitudes	
Sigh frequently or "air hunger"	
Have shortness of breath with moderate exertion	
Experience swelling of the ankles, especially at end of day	
Blush or face turns red for no reason	
Experience a dull pain or tightness in chest and/or radiate into left arm, worse on exertion	
Have muscle cramps on exertion	

Section 11	
Rarely break out into a sweat	
Use aluminum cooking equipment	
Have mercury amalgams	
Heat food in plastic containers in microwave	
Have your clothes dry-cleaned	
Eat "fast-food" > 2 times a week	
Drink tap, well or bottled water	
Have strong body odor	
Have acne on face or buttocks	
Drink < 4 cups water a day (approximately 30 oz)	
Live in a large urban or industrial area	
Use lawn or garden chemicals	
Have less < 1 bowel movement per day	
React to small amounts of alcohol	
Sit on your computer 3+ hours a day	
Exercise < 3 times a week	
Use tobacco products	
Eat large fish (sword fish, tuna, shark, tilefish) more than once a week	
Urinate small amounts of dark urine only a few times a day	

Frequently exposed to solvents and chemicals at work or at home	
Feel any of the following: wired, increased aches in muscles and joints, anxiety, palpitations, sweating, dizziness when using caffeine	
Have a negative reaction when you consume foods containing MSG, sulfites or other preservatives	

NUTRITION FREQUENCY					
Food/Drink	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Caffeine					In what form?
Soda/Soft Drinks (diet or regular)					What type(s)?
Alcohol					What type(s)?
Herb tea					What type(s)?
Red Meat					Beef, Lamb, Sausage/deli
White Meat					Poultry, Pork Sausage/deli
Eggs					
Fish/Shellfish					
Nuts & Seeds					
Fruits					Canned, Fresh, Frozen
Vegetables					Canned, Fresh, Frozen
Lentils & Beans					Canned, Fresh, Frozen
Oils / fats (e.g., olive, butter)					What type(s)?
Dairy Products					Milk, Yogurt, Cheese, Butter
Soy Products					What type(s)?
Whole grains					What type(s)?
Grain-based products					Bread, Pasta, Crackers
"Junk / Fast Food"					What type(s)?
Fried Foods					What type(s)?
Artificial Sweeteners					Aspartame Equal Sucralose, Truvia

Chewing Gum					What type(s)?

How many times each week do you eat each meal at home (vs. out)?	Breakfast, Lunch, Dinner
Approximately how many **ounces** of water do you drink per day?	oz Bottled, Filtered, Tap

Nutrition - 3-Day Food Diary Record information as soon as possible after the food has been consumed. Please include all beverages, even water.		
Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack
Dinner	Dinner	Dinner

Snack	Snack	Snack

Thank you for taking the time to complete this questionnaire.

Jennifer Brennan, MS, CNS, NNCP
Nutrition and Integrative Health

Notice of Privacy Practices

All patient information is protected and the privacy of your medical information is important to Jennifer Brennan. As a client of Jennifer Brennan a record of your care and services will be created. This record is required to provide you with quality care and to comply with certain legal requirements. Jennifer Brennan will not use or disclose your medical information for any purpose, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to Jennifer Brennan at the address below. Jennifer Brennan may use medical information about you to provide you with medical treatment or services and may disclose medical information about you to doctors, nurses, or other health care providers to assist them in treating you. Jennifer Brennan may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

Services to Be Provided

Jennifer's goal is to help you achieve the highest state of health consistent with your own goals. Nutritional services can serve as an excellent adjunct to a medical doctor's treatment, but are not a substitute for that treatment. Services offered as a part of this consultation may include education about nutrition and supplements, personalized whole foods and dietary suggestions, meal plans, lifestyle modifications, nutritional supplement suggestions, such as but not limited to vitamins, minerals, herbs, amino acids and fatty acids.

Client Rights and Responsibilities

It is your responsibility to fully disclose health information to Jennifer. As service progresses, inform her of changes that occur, including medication and health changes. You have the right to respectful, courteous care and can refuse to follow any or all recommendations provided as a result of this consultation. You have the right to choose another practitioner for any reason and to request that health information be disclosed to another practitioner or health care provider.

Fees and Charges

Payment for the consultation is due at the time services are rendered. Except in emergency situations, you will be charged for missed appointments without 24 hours notice. The initial one hour consultation has a fee of $100.00 and the follow up appointments are $50.00 each half hour. The fee for missed appointments is $75.00. Emails and phone calls longer than 10 minutes will be billed at $25 per15 minutes. There is a returned check fee of $ 50.00

Supplement Safety

The historical record and modern research indicate that herbs and supplements most often used for healthcare have a good safety record. Similarly, confirmed cases of herb, nutrient and drug interactions are rare. However, adverse events can occur after using any active substance, including allergic response. Therefore it is imperative that you disclose to Jennifer: 1) all medications, supplements and herbs currently in use, 2) any liver or kidney disease (past or present), 3) any allergies, 4) if you plan to become pregnant or are currently pregnant or breastfeeding. It is important to stay within the dosage recommended. You are expected to inform your physicians of any nutritional supplement or herb use. Any suggestion that the effect of a drug is being altered by simultaneous use of an herb or nutritional supplement should be reported directly to all health professionals involved. It is also advisable to stop taking herbs and supplements 7 days before and after a surgical operation,

and/or in the event of being prescribed a new medication.

Informed Consent

I am solely responsible for the decision to see Jennifer Brennan, MS, CNS, NNCP for Nutrition Services. I have reviewed this document, including safety of supplements, services to be provided, cancellation fees, my responsibilities as a client, and the Notice of Privacy Practices. I understand Jennifer is not a physician and therefore cannot diagnose or treat disease, or prescribe drugs. If I have not already done so, I agree to consult a medical doctor for any serious or life-threatening disease conditions, either for myself or someone under my guardianship. I have had the opportunity to ask Jennifer questions regarding the proposed services, this consent form, and other pertinent information and have received satisfactory explanations. I understand that I am free to discontinue service(s) at any time.

Client's Name _____

Client Signature: _____ Date: _____

Parent or Guardian Signature
(if client is under 18 years old): _____ Date: _____

Witness/Practitioner Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION

Card Holder Information:

Name on Card: _____

Home Address: _____

_____

Phone Number: _____

Card Number: _____

Expiration Date:_____

Three-Digit Security Code:_____

Card Type:_____(MasterCard, Visa, Discover, American Express)

Zip Code Associated with the Credit Card: _____

"I authorize The Mindful Heart LLC to charge this credit card for each appointment unless otherwise specified."

Cardholder Signature:_____

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