



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 1 TEASPOON 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 ORIGINAL CONTAINERS 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	
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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 BREASTFEEDING?

ARE YOU ACTIVELY TRYING TO CONCEIVE?

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	
	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				
<input type="checkbox"/> ACCEPTING	<input type="checkbox"/> ANXIOUS OR NERVOUS	<input type="checkbox"/> ANGRY	<input type="checkbox"/> CAPABLE	<input type="checkbox"/> COMPASSIONATE
<input type="checkbox"/> DETERMINED	<input type="checkbox"/> DREADFUL	<input type="checkbox"/> EMPOWERED	<input type="checkbox"/> ENTHUSIASTIC	<input type="checkbox"/> FORTUNATE
<input type="checkbox"/> GUILTY	<input type="checkbox"/> HAPPY	<input type="checkbox"/> HOPEFUL	<input type="checkbox"/> HURT	<input type="checkbox"/> INSPIRED
<input type="checkbox"/> LONELY	<input type="checkbox"/> LOVED	<input type="checkbox"/> PEACEFUL	<input type="checkbox"/> RESENTFUL	<input type="checkbox"/> RESIGNED
<input type="checkbox"/> SAD	<input type="checkbox"/> SCARED	<input type="checkbox"/> TERRIFIED	<input type="checkbox"/> TIRED	<input type="checkbox"/> 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.	
<u>DATE</u>	<u>EVENT</u>

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:

0 = 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
 Sinus problems
 Hay fever
DISCHARGE
 Sneezing attacks
 Excessive mucus formation
Total

Craving certain foods
 Excessive weight
 Compulsive eating
 Water retention
 Underweight
Total

Frequent or urgent
 urination
GENITAL ITCH OR

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/SHELLFIS H					
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 per 15 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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