Nutrition Health History

Name:_____ Date: _____

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

1 _____

2 _____

3 _____

4 _____

5 _____

Current Supplements _____

_____

Vegetarian? Y/N Type _____ How many fruits and vegetables do you eat daily? _____

Metal in your body? (fillings, staples, pins, etc)? Y/N_____

Allergies? Y/N Details _____ Surgeries? Y/N Details _____

_____ Root Canal? Y/N Wisdom Teeth Removal? Y/N Oral Surgery? Y/N

History of Body or Head Trauma/Concussion? Y/N Details _____

Hospitalizations (exclude surgies) Y/N Details _____

Family History of Disease (Diabetes, Heart Disease, Cancer, etc.) _____

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
___ Auto Immune 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 Apnea / 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: Scale1 – 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/weeks

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
___ Movement ___ 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

FECAL 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 Food
___ 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 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 Eyebrow
___ Cold Hands/Cold Feet

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

Nutrition Case History

Instructions:

~ Bring all vitamins, minerals and supplements you are currently taking.
~ Please do not take anything, except necessary medication for 24 hours prior to your appointment.
~ Avoid lotions on your hands and feet the day of the testing.
~ Drink water before you appointment as dehydration make it difficult to get accurate readings.
~ Please eat within 2 hours of your appointment so your blood sugar is level.
~ Avoid caffeine for a minimum of 4 hours before testing. 24 hours is best.

Waiver of Liability Form for Nutrition Services Rendered at Northern Light Care (NLC)

I, the client, choose to receive a nutrition status screening using Hair Analysis. The opinions received may include information on stress reduction, nutritional suggestions, including supplements. I agree to communicate with NLC any concerns I have before or after involving the testing.

I understand that NLC does not treat, diagnose illness, disease, or any physical or mental disorder, not do they prescribe medical treatment or pharmaceuticals. NLC is not a primary care facility and the treatments are natural and holistic. The nutrition visit at NLC is provided to clients on a cash basis, we do not file or submit insurance claims. NLC will provide a receipt that can be submitted, but the diagnosis codes must be provided by a referring medical doctor.

I acknowledge that any opinions from NLC are not a substitute for medical examination or diagnosis, and it is recommended that I see a primary care health provider for that 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 NLC immediately. All medical information given is strictly confidential.

Patient Name _____ Birth Date _____
Street Address _____
City, State, Zip _____
Phone _____ Email _____

Client Signature _____ Date _____