Nutritional Intake Form

Contact Information:

Last Name: _____ First Name: _____ M.I.: _____

Preferred Name: _____ Gender: ☐ M ☐ F DOB: ___/___/_____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (*home*)_____ (*cell*) _____ (*work*)_____

Is it okay to leave a voice message? ☐ Home ☐ Cell ☐ Work ☐ None

Email Address: _____Is it okay to correspond with you by email? ☐ Yes ☐ No

***NOTE:** Email is not a secure method of communication.*

Emergency Contact: _____ Phone: _____

Insurance

Do you have insurance? ☐ Yes ☐ No

Insurance Name: _____ Phone #: _____

Policy/ID Number: _____ Group Number:_____

Secondary Insurance? ☐ Yes ☐ No

Insurance Name: _____ Phone #: _____

Policy/ID Number: _____ Group Number: _____

MEDICAL RELEASE: I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

AUTHORIZATION OF PAYMENT: I authorize payment of medical benefits directly to Goodhealth Chiropratic

I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

Signature:_____Date:_____

Healthcare Provider Information

Who is your primary care physician? Name:_____ Phone: _____

When was your last physical exam?_____Are you currently under the care of a specialist? ☐ Yes ☐No

Name:_____ Address/Phone:_____

Social History

Do you use tobaccos products? ☐ Yes ☐ No Which ones (cigarettes, chew, etc.)?_____

Did you use tobacco products in the past? ☐ Yes ☐ No For how long? _____

Do you drink alcohol? ☐ Yes ☐ No How many alcoholic beverages per week?_____

History of alcoholism? ☐ Yes ☐ No Have you ever received treatment? ☐ Yes ☐ No

Do you use any recreational drugs? ☐ Yes ☐ No Which ones?_____

History of drug addiction? ☐ Yes ☐ No Have you ever received treatment? ☐ Yes ☐ No

How many hours of sleep do you get on average?_____ Do you have trouble falling asleep? ☐ Yes ☐ No

Or staying asleep? ☐ Yes ☐ No Do you wake feeling refreshed? ☐ Yes ☐ No

What are your hobbies?_____

What is your current stress level? ☐ Mild ☐ Moderate ☐ Severe

Past Medical History

Which of the following conditions have you had? Please check:

☐ Abscesses	☐ Asthma	☐ Cancer	☐ Chicken Pox	☐ Cold sores
☐ Diabetes	☐ Eating Disorder	☐ Epilepsy	☐ Gallstones	☐ Goiter
☐ Heart Disease	☐ Hepatitis	☐ Kidney disease	☐ Leukemia	☐ Malaria
☐ Measles	☐ Mononucleosis	☐ Mumps	☐ Parasites	☐ Peritonitis
☐ Pleurisy	☐ Pneumonia	☐ Prostatitis	☐ Rheumatic fever	☐ Skin disease
☐ Stroke	☐ Tonsillitis	☐ Tuberculosis	☐ Typhoid	☐ Warts
☐ Worms	☐ Lactose Intolerant	☐ Pelvic Inflammatory Disease		

Other: _____

Family History

Does anyone in your family have a history of the following? (please check)

☐ Heart Disease	☐ Asthma	☐ Stroke	☐ High Blood Pressure
☐ Anemia	☐ Arthritis	☐ Kidney Disease	☐ Alcoholism/Drug Addiction
☐ Arthritis	☐ Hay fever/Hives	☐ Mental Illness	☐ Alzheimer's
☐ Depression	☐ Lung Disease	☐ Osteoporosis	☐ Thyroid Disease

Cancer (Type)_____ Diabetes (Type)_____

Any other relevant family history? _____

Nutrition Information Continued...

How would you describe most meals: ☐ Relaxed ☐ Rushed ☐ Standing in front of TV
☐ Seated at the table ☐ In the car ☐ Alone ☐ With family and friends

Do you eat a wide variety of foods? ☐ Yes ☐ No ☐ Unsure

How often do you consume sugar? ☐ Daily ☐ 3-4 times/week ☐ Occasionally ☐ Seldom/Never

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Just right

How many times have you tried to lose weight? _____

Age of first attempt: _____ What did you try? _____

Have you ever used any of the following for weight control? If yes, please explain.

Commercial diet programs	☐ Yes ☐ No	_____
Liquid diets	☐ Yes ☐ No	_____
Fad diets	☐ Yes ☐ No	_____
Prescription diet pills	☐ Yes ☐ No	_____
Over-the-counter diet pills	☐ Yes ☐ No	_____
Laxatives	☐ Yes ☐ No	_____
Diuretics	☐ Yes ☐ No	_____
Ipecac Syrup	☐ Yes ☐ No	_____
Vomiting	☐ Yes ☐ No	_____
Self Designed Program	☐ Yes ☐ No	_____
Restricted Caloric Diets	☐ Yes ☐ No	_____
Other:	☐ Yes ☐ No	_____

Do you experience periods in which you eat uncontrollably? ☐ Yes ☐ No

How often? _____

How much time goes by between meals on average? _____

Please specify how many of the following you drink per week?

_____ Alcohol	_____ Coffee	_____ Decaf Coffee	_____ Diet drinks/aids
_____ Fruit juice	_____ Black tea	_____ Green tea	_____ Sports drinks
_____ Herbal tea	_____ Soft drinks	_____ Diet soft drinks	_____ Water

Digestive Screening Questionnaire

Name _____ **Date** _____

		History
yes	no	Have you had your zinc levels checked in the last 6 months
	_____	How many glasses of water do you drink per day (please indicate a #)
	_____	How many servings of fruit do you EAT each day (please indicate a #)
yes	no	Do you eat sushi
yes	no	Do You consume any dairy products
yes	no	Have you taken antibiotics in the last 6 months or for an extended period of time during the last 10 years
yes	no	Have you traveled out of the country in the last 10 years
yes	no	Have you ever had any type of food allergy / sensitivity testing performed
		Have you been diagnosed with any of the following
yes	no	Ulcers – gastric duodenal
yes	no	GERD / Reflux
yes	no	Pancreatitis
yes	no	Celiac disease
yes	no	IBS / IBD / Colitis
		Do you take
Yes	No	OTC antacids
Yes	No	OTC Laxatives / Fiber
Yes	No	Other digestive aids used (please list):
Yes	No	Prescription medicines for digestion (please list):

		Upper GI – Burning, GERD, Indigestion
Yes	No	My stomach burns / hurts even when empty. (Not hunger pangs)
Yes	No	Eating or drinking relieves above
Yes	No	Eating or drinking makes it worse
Yes	No	My stomach starts burning or I get bloated immediately after or while eating or drinking
Yes	No	My Stomach starts burning or I get bloated 30 min to several hours after I eat or drink
Yes	No	Certain foods seem to make this worse (please list)
		What relieves this? (please list)
Yes	No	I have been diagnosed with "Reflux" or "GERD"
		If so, it is worse lying down OR all the time (circle one)

For professional use only.

		Lower GI – Gas, Bloating, Cramping, Constipation, Diarrhea
Yes	No	I have at least 1 normal bowel movement each day. *Normal is a large, med. brown, well formed stool w/o cramping, strain or pain*
		My stools are often:
Yes	No	Small and round or hard
Yes	No	Thin - pencil like
Yes	No	Pasty or fatty
Yes	No	Loose
Yes	No	Very foul
		I often get really gassy and:
Yes	No	It's not nice but not really offensive
Yes	No	Very offensive and embarrassing
Yes	No	Do any foods aggravate ? please list
Yes	No	I often have to strain to have a bowel movement
Yes	No	I often have cramping and pain with a Bowel movement
Yes	No	I often have abdominal cramping and pain even without a bowel movement.
Yes	No	I notice undigested food in my stool—especially vegetable matter.

Nutritional Exam points and history

Zinc	Strong	Med	Mild	None
HCL point	Strong	Med	Mild	OK
Enzyme	Strong	Med	Mild	OK
Gallbladder	Strong	Med	Mild	OK
Liver	Strong	Med	Mild	OK

Please list the following as it applies:

Prescription medicines for digestion:

_____

_____

_____

Foods that make GERD, heartburn worse:

_____

_____

_____

What relieves heartburn or GERD:

_____

_____

_____

For professional use only.

Patient Health History

Health Concerns: Please list your main health concerns in order of importance.

Describe your primary concern_____

When did it start? _____ Has this been diagnosed? ☐ Yes ☐ No Diagnosis:_____

Are you currently receiving any treatment for this condition? Please describe:

_____

Other concerns:_____

What would you most like to accomplish on your first visit?_____

_____

Height:_____ Blood Type: _____

Weight: Current_____ Last year_____ Ideal_____ Highest Weight _____

Have you recently lost/gained weight? ☐ Yes ☐ No _____

Was this an intentional change? ☐ Yes ☐ No

Do you weigh yourself? ☐ Yes ☐ No How often? _____

Are you concerned with your weight? ☐ Yes ☐ No

Allergies:

Please list any allergies you have to medications, environment, and food. What is your reaction?

Allergen	Reaction
_____	_____
_____	_____
_____	_____

Medications:

List all prescriptions, over-the-counter medications and herbal, homeopathic, hormonal, nutritional (vitamins/minerals) supplements, you are currently taking:

Medications	Reason	Dosage	Date Began	Effective (Y/N)

please attach a separate sheet if necessary to list all medications

Lifestyle Habits:

Occupation: _____ Hours per week: _____

Relationship Status: ☐ Single ☐ Married ☐ Partnership ☐ Divorced ☐ Separated ☐ Widowed

With whom do you live? ☐ Spouse ☐ Partner ☐ Parents ☐ Friends ☐ Children ☐ Alone

Are you sexually active? ☐ Yes ☐ No

Do you or your partner use contraception? ☐ Yes ☐ No If so, what type(s)?_____

Are you pregnant? ☐ Yes ☐ No ☐ Not sure Number of children _____

Exercise:

Are you currently exercising: ☐ Yes ☐ No

List type, duration, frequency, and intensity of exercise activities:

_____

_____

_____

Have you exercised in the past year? ☐ Yes ☐ No

Do you have any physical conditions that limit your ability/safety to exercise? ☐ Yes ☐ No

Please specify: _____

Nutrition Information

On a scale of 1-10 (10 being extremely healthful), how do you rate your diet? _____

Please describe any current dietary restrictions that you may have (vegan/vegetarian/celiac…):

_____

Do you have any food allergies? ☐ Yes ☐ No If yes, please describe _____

_____

Have you made any recent changes to your diet? ☐ Yes ☐ No If yes, please describe _____

_____

What foods do you consume on a regular basis? _____

_____

What top five foods do you crave? _____

_____

What top five foods do you avoid? _____

_____

Do you snack during the day? ☐ Yes ☐ No What: _____

How many times per week do you eat breakfast? _____ What time? _____

What is your typical breakfast? _____

Please specify how many times you eat the following meals out to eat per week:

_____ Breakfast _____ Lunch _____ Dinner

How many days do you eat: _____ Breakfast _____ Lunch _____ Dinner

List restaurants you usually choose: _____

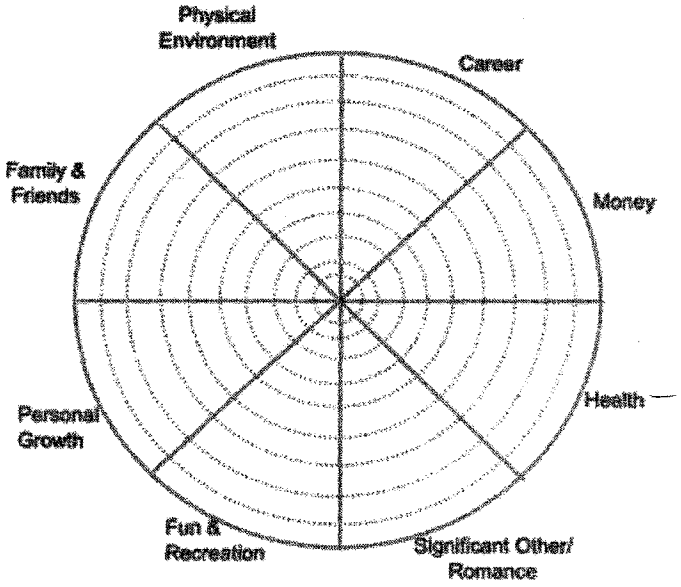
Do you generally cook your own meals? ☐ Yes ☐ No How often? _____

Do you like to cook? ☐ Yes ☐ No _____

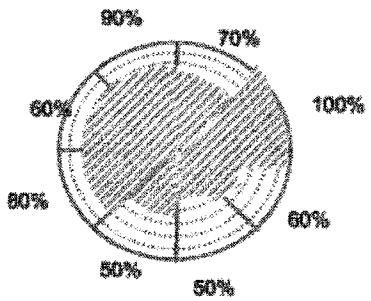
Where do you do most of your grocery shopping? _____

Wheel of Health

Please ***shade in*** your level of satisfaction in each area of your life. For example, if you are extremely happy in your career, shade the entire pie section of "Career"



Example:



How did you hear about us?_____

Please sign and date, indicating that you are consenting to treatment at Goodhealth Chiropractic.

_____ _____

Signature Date

_____

Signature of Legal Guardian (if patient is under 18)

Please bring any recent lab work or imaging results you have to your initial visit.

Thank you for taking the time to fill out this form. I realize it is long, and appreciate your responses. This information allows me to provide you with the best possible healthcare. Please feel free to ask any questions along the way. I look forward to working with you.

Dr. Jamie Gutheil D.C.

Please fill out forms before your visit. Bring forms with you to your visit or they can be emailed to drjamiedc@gmail.com or mailed to:

Goodhealth Chriopractic
214 Judah Street
Roseville, Ca. 95678

What do you know about Dr. Jamie's approach to health? _____

_____

What three expectations do you have from this visit to our clinic?

1. _____
2. _____
3. _____

What expectations do you have of me personally as your physician? _____

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Please check the box that is most appropriate. (Rate from 0 to 10, 10 being 100% committed)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

_____ _____

_____ _____

What behaviors or lifestyle habits do you currently engage in that are detrimental to your health?

_____ _____

_____ _____

What potential obstacles do you foresee that may interfere with adhering to any therapeutic treatment we will be sharing with you? _____

_____

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making? _____

_____

What do you LOVE to do? _____