# Nutritional Intake Form

**Rooted in Nutrition**
michelle@rootedinnutrition.ca

| | |
|---|---|
| Name: | Date: |
| Email: | Address: |
| Phone: | Cell: Other: |
| Weight: Height: | DOB: |

*Please answer the following questions to the best of your ability. Use extra paper if required.*

What is the purpose of your visit today—and what would you like to accomplish at this visit?

Have you ever been diagnosed with an illness or health condition? If yes, list below. List medication (if taken)

Do you wish to gain or lose weight? Circle if appropriate. How much? _____

Have you tried weight loss/gain programs in the past? If yes, list below and briefly tell me if you were successful, how much you lost/gained, and when and why you stopped the program(s):

What level of stress do you feel you experience on a daily basis (1-10)? _____
(1=minimal, 10= unbearable.)

Note which causes you stress & rate from 1-10: finance, career, personal/emotional health, martial, health, physical injuries or disabilities, family in general, kids, spiritually, unfulfilled expectations, other: Please CIRCLE

| | | | |
|---|---|---|---|
| Finance | 1 2 3 4 5 6 7 8 9 10 | Marital | 1 2 3 4 5 6 7 8 9 10 |
| Career | 1 2 3 4 5 6 7 8 9 10 | Physical Injuries/Illnesses | 1 2 3 4 5 6 7 8 9 10 |
| Family | 1 2 3 4 5 6 7 8 9 10 | Health | 1 2 3 4 5 6 7 8 9 10 |
| Personal | 1 2 3 4 5 6 7 8 9 10 | Unfulfilled Expectations | 1 2 3 4 5 6 7 8 9 10 |

What time do you go to bed? _____ Awake in morning? _____

Do you sleep through the night? _____ Do you nap & how long? _____

What do you do for exercise, how often and how long each time? List activities + frequency.

**Family History of Disease:**

| | |
|---|---|
| Mother | |
| Father | |
| Siblings: | |
| Grandparents | |
| Other | |

Please list any that you currently are taking or have taken, how often & doses (use separate sheet if necessary)
1) Supplements including vitamins, enzymes, homeopathics, probiotics,
2) Medications including prescriptions, over-the-counter remedies, and antibiotics.

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**Eating/ Digestion:**

| | |
|---|---|
| Do you have any known food allergies or intolerances? | |
| Describe your appetite | |
| # of Meals per day & times (approx. or range) | |
| # of Snacks per day & times (approx. or range) | |
| Favourite foods & how often do you eat them? | |
| Do you have cravings, what foods, when do you eat them? | |
| Are there foods you absolutely refuse to eat or dislike? | |
| Do you feel there are restrictions to your diet because of other people or your lifestyle? | |
| Do you eat meals: with family, home alone, on-the-run, in car, restaurant, take-out/fast food (Circle) | |
| Do you have difficulty digesting any foods? List | |
| Do you have pain, cramping, bloating, gas, headaches, bad breath, diarrhea, constipation with foods. Does it occur before, after, or during meals. (Circle) | |

**Stool:**

| | |
|---|---|
| Number of times per day? | |
| Do you strain? How often? | |
| Constipation? How often? | |
| Irritable Bowel? What food(s) set it off? | |
| Diarrhea? How often? | |
| Bristol Stool Chart #? | |

Please complete the following using:
**1**- mild or rarely occurring, **2**-moderate or regularly occurring **3**- for severe of often occurring
OR leave BLANK if the issue does not pertain to you

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**Underactive Stomach**

Excessive gas, belching or bloating ____
Stomach bloated after eating ____
Sleepy, heavy or tired feeling after eating ____
Eat when rushed or in a hurry ____
Bad breath ____
Nausea after taking supplements ____
Acne ____
Undigested food in stool ____

**Overactive Stomach**

Stomach pain or burning sensation ____
Pain aggravated by worry or tension ____
Gastritis, gastric ulcer, hiatal hernia ____
Nausea or vomiting ____
Heartburn, or indigestion ____
Blood In stool ____
Lower back pain ____
Long term aspirin use ____

**Gallbladder**

Gall stones/ history of gall stones ____
Stool appears clay coloured ____
Constipation ____
High cholesterol blood/diet ____
Severe pain in right upper abdomen ____

**Pancreas**

Severe abdominal pain ___
Nausea and vomiting ____
Slow digestion ____
Fever ____
Alcohol addiction ____

**Liver**

Skin oily on nose and forehead ____
Jaundice ____
Acne, boils, rashes, psoriasis or eczema ____
Weight gain around abdomen ____
Difficulty loosing weight ____
Fat/greasy foods cause nausea/headache ____
Certain foods cause bloating/gas ____
High cholesterol blood/diet ____
Food allergies ____
Bad breath, body odor ____
Migraine headaches ____
Discomfort under right ribcage ____
Irritable, easily angered ____
Poor Concentration ____
Constipation ____

**Dysglycemia**

Hungry up to 3 hours after eating ____
Strong cravings for sweets/starches ____
Nervousness soothed by eating ____
Irritable if late for or skip meal ____
Overweight ____
Addicted to coffee with sugar or cola ____
Frequent midnight snacks ___
Family history of diabetes ____
Fatigue ____
Frequent headaches ____
Fainting spells ____
Depression ____
Lose temper easily ____

**<u>The Intestinal System</u>**

**Candidiasis**

Extreme fatigue ____
Frequent use of antibiotics ____
Crave sugars, bread, alcohol ____
Tonsillitis, strep throat ____
Skin flushes ____
Frequent use of antacids ____
F: PMS ____

Recurrent vaginal /bladder infections ____
White coated tongue, oral thrush ____
Headaches ____
Itchy, watery or dry eyes ____
Chronic indigestion ____
Always cold especially hands/feet ____
Pain in pelvic area ____

F: endometriosis/ovary issues ____
Abdominal gas and bloating ____
Hives, psoriasis, acne, skin rash ____
Canker sores ____
Jock itch ____
Depression/anger for no reason ____

Chronic diarrhea ____
Food and chemical sensitivities ____
Excessive ear wax ____
Unexpected/unexplained weight gain ____
Athletes foot, finger/toenail fungus ____
Memory loss, mental confusion ____

| | | | |
|---|---|---|---|
| Anxiety/panic attacks | ____ | Inability to concentrate | ____ |
| Phobic /compulsive | ____ | Lethargy | ____ |
| Mood swings, irritability | ____ | Itchy ears or nose | ____ |

**Parasites**

| | | | |
|---|---|---|---|
| Forgetfulness | ____ | Slow reflexes | ____ |
| Gas and bloating | ____ | Unclear thinking | ____ |
| Loss of appetite | ____ | Yellowish or pale face | ____ |
| Fast heartbeat, or heart pain | ____ | Pain in navel | ____ |
| Blurry or unclear vision | ___ | Eating more than usual but still hungry | ____ |
| Numb hands | ____ | Pain in the back, thighs, shoulders | ____ |
| Drooling while sleeping | ____ | Dry lips during the day | ____ |
| Grind teeth while sleeping | ____ | Lethargy; chronic fatigue | ____ |
| Dark circles under the eyes | ____ | Cancer | ____ |

**Circulatory /Cardiovascular System**

| | | | |
|---|---|---|---|
| General fatigue or weakness | ____ | High stress life style | ____ |
| Smoking | ____ | Drinking 2 or more cups of coffee/day | ____ |
| Poor concentration or memory | ____ | Regular use of red meat or dairy | ____ |
| High fat/high cholesterol diet | ____ | Nervousness/anxiety/tension/worry | ____ |
| Low fibre diet | ____ | Sleepy when sitting up | ____ |
| Cold hands and feet | ____ | Varicose veins | ____ |
| Too little exercise | ____ | Short of breath climbing stairs | ____ |
| Chest pain | ____ | Tingling in lips/fingers/arms/legs | ____ |
| Very rapid or slow heart beat | ____ | Drink less than 6 glasses of fluids a day | ____ |
| Water retention | ____ | | |

**Lymphatic/Immune System**

**Allergies**

| | | | |
|---|---|---|---|
| Acne, psoriasis, eczema | ____ | Rapid pulse, heart irregularities | ____ |
| Frequent headaches | ____ | Hay fever | ____ |
| Periods of blurred vision | ____ | Frequent cravings for certain foods | ____ |
| Repeated ear trouble | ____ | Hyperactivity | ____ |
| Dizzy spells | ____ | Periods of confusion | ____ |
| Muscle cramps or spasms | ____ | Abnormal body odor | ____ |
| Joint pain, stiffness | ____ | Excessive sweating, night sweats | ____ |
| Frequent night urination | ____ | Bowel disease: IBS, IBD, Crohn's, etc | ____ |
| Wheezing | ____ | Pale face | ____ |
| Hives | ____ | Nose runs constantly | ____ |
| Nosebleeds | ____ | Bloating /gas after eating certain foods | ____ |
| Canker sores | ____ | Dark circles under the eyes | ____ |
| Stuffy Nose | ____ | | |

**Thymus**

| | | | |
|---|---|---|---|
| Excessive sleep | ____ | Very susceptible to infections | ____ |
| Loss of appetite | ____ | Swollen glands: tonsils, throat, armpits | ____ |
| Headaches | ____ | History of: cancer, MS, Parkinson's | ____ |
| Feel puffiness in throat | ____ | Soreness on both sides of neck | ____ |
| Flu-like symptoms often occur | ____ | Lupus | ____ |

**Respiratory System**

| | | | |
|---|---|---|---|
| General fatigue or weakness | ____ | Frequent illness/infection | ____ |
| High stress life style | ____ | Smoking | ____ |
| Bad breath and/or body odor | ____ | Drinking 2 or more cups of coffee a day | ____ |
| Bags under eyes | ____ | Allergies | ____ |
| Regular use of dairy products | ____ | Nervousness/anxiety/tension/worry | ____ |
| Exposure to toxins/chemicals | ____ | Bronchitis/asthma/pneumonia | ____ |
| Food/chemical sensitive's | ____ | Too little exercise | ____ |
| Excessive mucous | ____ | Short of breath climbing stairs | ____ |
| Chest pain | ____ | Swollen glands/puffy throat | ____ |

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| | | | |
|---|---|---|---|
| Lower abdominal pain | ____ | Frequent need to urinate | ____ |
| Joint pain | ____ | Lower back pain | ____ |
| Water retention | ____ | Drink less than 6 glasses of water a day | ____ |

**Reproductive**

| | | | |
|---|---|---|---|
| Smoking | ____ | Drinking 2 cups of coffee or more a day | ____ |
| Crave sugar/breads/alcohol | ____ | Have used antibiotics in past 10 years | ____ |
| Skin complexion problems | ____ | Regular use of dairy products | ____ |
| Exposure to toxins/chemicals | ____ | Low sex drive | ____ |
| Depressed and/or irritable | ____ | High fat/high cholesterol diet | ____ |
| Frequent yeast infections | ____ | Female: PMS, Menopause | ___ |
| Sudden weight gain/loss | ____ | Lower Abdominal pain | ____ |
| Headaches/migraines | ____ | Taking birth control pills | ____ |

**The Glandular /Endocrine System**

**Underactive Thyroid**

| | |
|---|---|
| Distinct, lethargic tiredness or sluggish | ____ |
| Cold hands or feet | ____ |
| Gain weight easily, not easy to loose | ____ |
| Constipation | ____ |
| Low energy in mornings | ____ |
| Low pulse rate | ____ |
| Low body temperature especially at bed | ____ |
| Hair dry, brittle, dull, lifeless | ____ |
| Flaky, dry rough skin | ____ |
| Feel stiff after sitting for some time | ____ |
| High cholesterol | ____ |
| Diminished sex drive | ____ |

**Adrenals**

| | |
|---|---|
| Stress or upsets cause exhaustion | ____ |
| Blood pressure can decrease quickly | ____ |
| Perspire excessively | ____ |
| Neck and or shoulder tension | ____ |
| Frequent headaches | ____ |
| Occasional cold sweats | ____ |
| Tightness or lump in throat | ____ |
| High or low blood pressure | ____ |
| Rapid pulse | ____ |
| Short temper | ____ |
| Puffy face | ____ |

**Overactive thyroid**

| | |
|---|---|
| Losing weight without trying | ____ |
| Heart races while at rest | ____ |
| Warm or flushed at room temperature | ____ |
| Hands shake or tremble | ____ |
| Protruding tongue | ____ |
| Heart palpitations | ____ |
| Nervous behavior, hyperactivity | ____ |
| Insomnia | ____ |
| Increased appetite | ____ |
| Frequent bowel movements/diarrhea | ____ |
| Excessive sweating without exercise | ____ |

**Pituitary**

| | |
|---|---|
| Headaches affecting one side of head | ____ |
| F: loss of menstrual function | ____ |
| Moody | ____ |
| Overweight from waist down | ____ |
| Overweight from waist up | ____ |
| Excessive urination | ____ |
| Swelling in ankles, fingers and/or feet | ____ |
| Cold hands or feet | ____ |
| Pain in left side of upper neck | ____ |

**Nervous System**

| | | | |
|---|---|---|---|
| High stress lifestyle | ____ | Smoking | ____ |
| Drinking 2 cups of coffee or more a day | ____ | Crave sugar, bread, alcohol | ____ |
| Poor concentration/memory | ____ | Heavy alcohol consumption | ____ |
| Frequent mood swings | ____ | Depressed and/or irritable | ____ |
| Nervousness/anxiety/tension/worry | ____ | Insomnia/restless sleep | ____ |
| Muscle cramps | ____ | Feeling out of control | ____ |
| Too little exercise | ____ | Tingling in lips, fingers, arms, legs | ____ |
| Very rapid or slow heart beat | ____ | F: PMS/taking birth control | ____ |

| | | | |
|---|---|---|---|
| Headaches/migraines | ____ | Lower back pains | ____ |
| Low sex drive | ____ | | |

**Urinary System**

| | | | |
|---|---|---|---|
| Frequent illness/infections | ____ | Drinking 2 cups of coffee or more a day | ____ |
| Bad breath/body odor | ____ | Bags under eyes | ____ |
| Pain in lower back or abdomen | ____ | Frequent consumption of red meat | ____ |
| Regular use of dairy products | ____ | F: PMS | ____ |
| High fat/cholesterol diet | ____ | Urination issues | ____ |
| Alternating constipation/diarrhea | ____ | Recurrent bladder infections | ____ |

**The Structural Muscular/Skeletal System**

**Skeletal**

| | |
|---|---|
| Pain, swelling, stiffness in joints | ____ |
| Joint inflammation | ____ |
| Pain, stiffness, inflammation of spine | ____ |
| Facial pain | ____ |
| Joints make popping sound | ____ |
| Gout | ____ |
| Ankylosing spondylitis | ____ |
| Bones fracture easily | ____ |
| Gradual loss of height | ____ |
| Tooth loss/teeth falling out | ____ |
| Lack of exercise | ____ |
| Rounding of shoulders | ____ |
| F: menopause | ____ |
| Pain in forearm/bicep | ____ |
| Cramp in calf during sleep/exercise | ____ |
| Painful cramping of feet or toes | ____ |
| Teeth prone to decay | ____ |
| Malformation of bones | ____ |
| Insomnia | ____ |
| Muscles weak/weak grip | ____ |
| Diet high in meat, dairy, eggs | ____ |

**Neuromuscular**

| | |
|---|---|
| Muscles wasting in some part of body | ____ |
| Numbness or loss of sensation | ____ |
| Mood swings and/or depression | ____ |
| Blurred or double vision | ____ |
| Tingling/numbness 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 | ____ |

**Muscular**

| | |
|---|---|
| Muscle pain | ____ |
| Muscle weakness | ____ |
| Sprains, muscle strains | ____ |
| Muscle spasms | ____ |