

THE NUTRITION DOC – INTAKE FORM

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Date of your current appointment: _____

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Email address: _____ Date of Birth: _____

Age: _____ Occupation: _____

Single Married Divorced Partnership

How did you hear about my practice?

Friend (name): _____ T. Colin Campbell site

John McDougall site Health Care Practitioner The Rave Diet site Lecture

Vitamin Cottage TheNutritionDoc.com Center for Health

What are your four major health concern(s):

1. _____

2. _____

3. _____

4. _____

Are you taking any medications? Y N If yes, please list:
(Use the back of this form if needed)

1. _____ Dose: _____
2. _____ Dose: _____
3. _____ Dose: _____
4. _____ Dose: _____

Are you taking any vitamins, herbs, supplements, or homeopathic remedies? Y N
(Use the back of this form if needed).

1. _____ Dose: _____
2. _____ Dose: _____
3. _____ Dose: _____
4. _____ Dose: _____

Are you under a medical doctors care? Y N
Name of your physician(s):

1. _____ Phone: _____
2. _____ Phone: _____

Your Current Health Goals:

Briefly describe your health goals:

Your Current Health Problems:

List any specific symptoms or health conditions that are troubling you:

1. _____ Length of time _____
2. _____ Length of time _____
3. _____ Length of time _____
4. _____ Length of time _____
5. _____ Length of time _____
6. _____ Length of time _____

Additional comments about the purpose for your appointment:

YOUR HEALTH HISTORY

The general state of your health is: excellent good average fair poor

Please describe your average daily energy level from 1-10 (10 is the highest) _____

What time of day is your energy level the best? _____ Worst? _____

STRESS EVENTS

Please list the **5 most significant**, stressful events in your life (i.e., *loss of a relationship, trauma, abuse, a failure, serious illness or accident, a regret, or any stressful life experience*) from the recent to the most distant.

Check box if this stress has affected you recently:

- 1. _____ Date: _____ Affects me
- 2. _____ Date: _____ Affects me
- 3. _____ Date: _____ Affects me
- 4. _____ Date: _____ Affects me
- 5. _____ Date: _____ Affects me

Are you currently working with a professional counselor, psychologist, social worker, pastor, or other therapist? Y N

If yes, do you feel like you are benefiting from the therapy or service you receive? Y N

VACCINATIONS

Please place an "X" by the following vaccinations you have had.

If you experienced any known complications associated with vaccines or illness, please explain:

DTaP _____ Chickenpox _____ MMR _____
 Polio _____ Flu/H1N1 _____ Pneumonia _____
 Smallpox _____ Hep B _____ Hib _____ HPV _____
 Others _____

PREVIOUS SURGERIES AND/OR HOSPITALIZATIONS: Indicate reason for each:

- 1. _____ Reason: _____ Date: _____
- 2. _____ Reason: _____ Date: _____
- 3. _____ Reason: _____ Date: _____
- 4. _____ Reason: _____ Date: _____

DO YOU HAVE ANY KNOWN ALLERGIES? Y N

Foods: _____

Drugs: _____

Environmental: _____

FAMILY HISTORY

Please list ages, health problems and if deceased, cause of death:

Relative	Living (age)	Health Problems	Died (age)	Cause of Death
Mother				
Father				
Brother(s)				
Sister(s)				
Mom's mom				
Mom's dad				
Dad's mom				
Dad's dad				

What is your nationality or ethnicity (if known)? _____

SOCIAL HISTORY:

You currently live with? Spouse Partner Same-Sex Partner Parents
 Friends Children Alone

Are you? Married Separated Divorced Widowed Single

Are you in a supportive relationship? Y N

Explain: _____

What is your current level of education? _____

Are you satisfied with this? Y N

Which of the following do you currently use?

Please note "C" for current use. Indicate past use by "P".

Alcohol ____, Wine ____, Beer ____, Pipes ____, Cigarettes ____, Chew ____,
 Cigars ____

Usage/day, week _____ Number per day/week _____ X years _____

Coffee ____, Regular ____, Decaf ____, Number of cups/day, week? _____

DRUGS/MEDICATIONS:

Do you take hormone replacement? Y N

If yes, which type? Rx, oral (pill, troche), transdermal (cream, patch), vaginal (suppositories), etc.

Hormone	Length of time	Dose	Delivery Method
Estrogen (estradiol)			
Progestins			
Bioidentical: Triest/ Biest			
Progesterone			
Testosterone			
DHEA			
Cortisone (corticosteroids):			
Insulin			

RECREATIONAL DRUGS (Past / Current): _____

OVER-THE COUNTER MEDICATIONS (NSAIDS, Aspirin, Antihistamines, Laxatives, Tums, etc.)

1. _____
2. _____
3. _____
4. _____

PLEASE LIST CURRENT PRESCRIPTON MEDICATIONS WITH DOSAGE(S):

Name of medication / dose Reason for use (Use back if necessary)

1. _____
2. _____
3. _____
4. _____

PLEASE LIST CURRENT VITAMINS, HERBS & HOMEOPATHIC MEDICINES:

Name / dose Reason for use (Use back if necessary)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

PERSONAL HABITS, SOCIAL

What activities or experiences do you enjoy most in your life?

- 1. _____
- 2. _____
- 3. _____

What are your main interests or hobbies? _____

What do you worry most about in life? _____

Do you exercise? Y N

If yes, what kind, how much, how often? _____

If no, why? _____

Do you have a religious or spiritual practice? Y N

If yes, what? _____

Do you enjoy your work? Y N

Do you take vacations? Y N

Have you ever traveled outside the United States? Y N

If yes, please list countries _____

Are you currently in a primary or committed relationship? Y N

On a scale of 1-10 (10 being great!) how happy or satisfying is the relationship? _____

Comments: _____

SLEEP

On a scale of 1-10 (10 being great), how would you rate your quality of sleep? _____

Do you have problems? circle (falling asleep or staying asleep)

Average total hours of sleep per night? _____

Do you awaken at night? Y N If yes, what time? _____ how many times? _____

Do you have difficulty falling back to sleep? Y N

Do you wake feeling refreshed? Y N

Do you sweat when you sleep? Y N

If yes, please describe: _____

ENDOCRINE

Please circle - Do you frequently feel too *cold* or *warm* or *normal* temperature?

When rising quickly from a lying position do you frequently get dizzy? Y N

If yes, how often? _____

Do you have difficulty perspiring? Y N

Do you perspire during exercise? Y N

Have you been experiencing a change in your weight? Y N

If yes, please explain: _____

What is your current weight? _____ Height? _____ Weight 1 year ago? _____

Do you need to snack or eat frequently to avoid a weak, sinking sensation? Y N

Have you ever been diagnosed with Metabolic Syndrome or type-2 Diabetes? Y N

If yes, are you on insulin? Y N

If yes, what are the type(s) and dose(s) _____

Have you ever been diagnosed with Hypothyroidism? Y N

Are you currently taking medication for your thyroid? Y N

If yes, what is the current brand and dose? _____

Do you have Hashimoto's? Y N Don't know (circle)

Have you ever been diagnosed with Hyperthyroidism? Y N

If yes, do you have Graves Disease? Y N

If yes, are you currently taking medications? Medication _____ dose _____

RAI? _____ Date: _____ Thyroidectomy? _____ Date: _____

Have you been diagnosed with a goiter, and/or nodules? Y N

Have you ever had/ or presently do have thyroid cancer? Y N

Type of cancer: _____ Stage: _____

Treatments undergone: _____

Have you had dental X-rays or other X-rays? Y N If yes, how many times? _____

Have you every been exposed to other forms of ionizing radiation (i.e., radioactive fallout, Iodine 131? Y N

If yes, when and where? _____

Do you use iodized salt? Y N

Do you eat seafood, seaweeds weekly? Y N

AUTOIMMUNE

Have you ever been diagnosed with an autoimmune disease (i.e., Diabetes I, Rheumatoid Arthritis, Lupus, Multiple Sclerosis, Scleroderma, Sjorgrens, Raynaud’s, Celiac Disease, Addison’s, etc.? Y N

If yes, which disease(s)? _____

Do you have immediate family members diagnosed with autoimmune disease? Y N

Have you ever been diagnosed with Celiac Disease or Gluten Intolerance? Y N

Has anyone in your immediate family been diagnosed with Celiac Disease or Gluten Intolerance? Y N

Are you on a gluten-free diet? Y N

Have you ever been exposed to pesticides, herbicides? Y N

Have you had any other chemical exposure? Y N

If yes, which chemical? _____

FEMALE REPRODUCTION

Age of your first menstrual period: _____ If periods have stopped at what age did they stop?

Are your cycles regular? Y N Periods begin every _____ days?

Number of days you bleed: _____

Are your periods **Heavy** or **Medium** or **Light** ? _____

Any cramps with period? Y N

If yes, explain: _____

Which best describes your blood (please circle)?

Pink Light red Dark red Medium red Clots

Do you have spotting or bleeding between your periods? Y N

If yes, explain: _____

Do you have premenstrual symptoms (PMS) (please circle)?

Breast tenderness Irritability Depression Headaches Mood swings Food cravings Water retention

Number of pregnancies: ___ Number of abortions: ___ Number of live births: ___

Number of miscarriages: _____

Any complications from pregnancies or deliveries? _____

Any problems getting pregnant? _____

Any problems carrying a pregnancy full term? _____

Do you get yearly PAP smears? Y N

Any abnormal PAP's? Y N

If yes, explain: _____

Do you do self-breast exams? Y N

Any breast lumps? Y N

Mammograms Y N

How often? _____

Thermograms Y N

Any abnormalities? Y N

If yes, please explain: _____

Do you have any nipple discharge? Y N

Are you sexually active? Y N How often? _____ Pain with intercourse? _____

Do you use birth control? Y N What type? _____

Have you ever been physically or sexually abused? Y N

MALE REPRODUCTION

Do you have a problem with? Comment: _____

Leaking or dribbling urine _____

Waking up frequently at night to urinate _____

Frequency of urination _____

Pain with urination _____

Feeble stream _____

Discharge from urethra _____

Loss of libido _____

Erectile dysfunction (ED) _____

Premature ejaculation _____

Sores, eruptions on penis/genitals _____

Have you ever had your prostate examined? Y N

If yes, last exam? _____

Have you ever had a prostate specific antigen (PSA) test? Y N

If yes, date of last test? _____ and result _____

Are you currently sexually active? Y N

What type of birth control/protection do you and your partner currently use?

Have you ever been physically or sexually abused? Y N

H.E.E.N.T

Have you ever had a head trauma? Y N

If yes, describe: _____

Do you get headaches? Y N

If yes (please circle):

Rarely 1x per week More than 1x per week Almost every day Daily

Vision Disturbances:

Check any that apply and comment:

- Change in vision recently _____
- Eye pain _____
- Red eyes _____
- Excessive tearing _____
- Double vision _____
- Spots or floaters in vision _____
- Discharge from eye _____
- Uncorrected visual deficit _____
- Glaucoma _____
- Macular degeneration _____
- Retinitis pigmentosa _____
- Cataracts _____
- Other problems with eyes _____

Do you have sinus problems? Y N

Do you have nose bleeds? Y N

DENTAL

Have you ever had fillings in your teeth? Y N

If so, how many? _____

Have you ever had your fillings replaced? Y N

If yes, when? _____

Have you ever had a root canal? Y N

If yes, when? _____ How often? _____

Do you get canker sores in your mouth? Y N

If yes, how often? _____

Do your gums bleed when you brush your teeth? Y N

Do you floss regularly? Y N

Do you use fluoride toothpaste? Y N

EARS

Have you had any loss in hearing? Y N

If yes, (circle) **Right Left Both**

Do you have ringing in your ears? Y N

If yes, (circle) **Right Left Both**

Do you have a history of recurring ear infections? Y N

If yes, approximate number _____ At what ages? _____

Did you take antibiotics for the infections? Y N

If yes, how often? _____

Do you experience (please circle):

Dizziness Blacking out/fainting Spinning of the room

Do you have difficulty swallowing? Y N

If yes, is it worse with (please circle) **solids** or **liquids**

Are there any changes in your voice? Y N

Do you have swollen glands around your neck? Y N

CARDO/RESPIRATORY

Do you have heart palpitations? Y N

Irregular heart rhythm? Y N

Do you have high blood pressure? Y N

If yes, what does it run? _____/_____

Do you have high cholesterol? Y N

If yes, please circle: **High total cholesterol High triglycerides**

High LDL cholesterol Low HDL cholesterol

Do you have a heart murmur? Y N

Do you have any history of heart disease? Y N

If yes, explain: _____

Do you get any pain or pressure in your chest? Y N

If yes, explain: _____

Do you get shortness of breath? Y N

If yes, does it occur with (please circle): **talking at rest during exertion**

When you sleep do you need your head to be elevated? Y N

How many pillows do you use? _____

Have you ever had (please circle): **Asthma Bronchitis Emphysema COPD**

Pneumonia Tuberculosis Cystic Fibrosis Sarcoidosis

Do you cough? Y N

If yes please circle: **Rarely daily**

If yes, do you bring up mucus? Y N If yes what is the color? _____

Do you have chest congestion? Y N

If yes, explain: _____

Have you ever had a chest x-ray? Y N

When was your last chest x-ray? _____

Was it normal? Y N

If no, please explain: _____

DIGESTION/ELIMINATION

Do you have any problems with (please circle): *gas bloating fullness after eating Belching flatulence heart burn GERD (reflux)*

If yes, please explain _____

How often do you have a bowel movement? _____

Do you every have any (please circle) *Blood Mucus Undigested food* in your stool?

What color is your stool? _____

Is your stool malodorous? Y N

Do you experience rectal itching? Y N

Do you have hemorrhoids? Y N

Does your stool tend to be (circle): *Loose Formed "Pellet/pebble"*

"pencil thin" large voluminous "greasy/oil slick on water"

Does your stool (circle) *float sink*.

Do you have (circle): *Constipation Diarrhea Alternating constipation/diarrhea*

How many times have you taken antibiotics (approximately)? _____

Comments: _____

Do you take pre or probiotics (i.e., L. acidophilus, bifidus)? Y N

Do you have pain in the stomach or surrounding area? Y N

If yes, please explain: _____

Do you have any of the following (please circle): *Loss of appetite Increase in appetite*

Nausea vomiting anorexia bulimia

Have you ever been diagnosed with the following (please circle): *Hepatitis A*

Hepatitis B Hepatitis C Gastric Reflux Ulcer Gallbladder problems

Crohn's Disease Ulcerative Colitis Irritable Bowel Syndrome Gastroparesis

KIDNEY/BLADDER

Have you had recurrent bladder infections? Y N

If yes, how often? _____

If yes how was it treated? _____

How many bladder infections have you had within the last 3 years? _____

Do you have any burning sensation during or after urination? Y N

Is your urine (please circle): *dark yellow bright yellow cloudy pale other*

Do you have any difficulty with wetting your undergarments? Y N

Do you have any history of (please circle): *kidney stones polycystic kidneys blood in the urine*

VASCULAR / HEMATOLOGIC

Any history of anemia? Y N

If yes, what kind? _____

Do you bruise easily? Y N

Have you ever received a blood transfusion? Y N

Do you have any history of (please circle): Y N

If yes, (circle) *intermittent claudication varicose veins stroke aneurysm*

Have you ever donated blood? Y N

Have you ever been declined for blood donations? Y N

If yes, explain: _____

Do you know your blood type? _____

MUSCULOSKELETAL/ NERVOUS SYSTEM

Do you have muscle or joint pain? Y N

If yes, explain: _____

Have you experienced a decrease in mobility? Y N

Are you under the care of a doctor, chiropractor, or physical therapist for pain? Y N

Is there any history of the following (please circle): *Gout Back pain Arthritis*

Osteoporosis other _____

Have you been experiencing any weakness? Y N

If yes, describe: _____

Have you noticed any numbness or tingling? Y N

If yes, describe: _____

Are you experiencing paralysis? Y N

If yes, describe: _____

Do you have any tremors? Y N

Do you have any involuntary movements, tics, etc?

If yes, describe: _____

SKIN

Do you have any rashes? Y N

If yes, describe: _____

Any changes in moles? Y N

If yes (circle) *Shape* *Size* *Symmetry* *Color*

Do you wear sunblock? Y N

Have you ever had skin cancer? Y N

If yes, explain: _____

Do you have any of the following skin problems (please circle): *Eczema* *Psoriasis*
Skin ulcers *skin depigmentation* *skin hyperpigmentation* *itchy patches on skin*
dry scaly patches *acne* *other* _____

Have you had a recent vitamin-D blood test? Y N

Additional area for important information you may wish to convey that has not been asked in the health survey.

Your signature below acknowledges that you have read and understand the following cancellation policy.

Patients must give 24 hours cancellation or reschedule notice or they will be charged \$50.00 for a missed appointment.

Signature

Date