THE NUTRITION DOC - INTAKE FORM

Dr. Connie Sanchez, N.D.
Live Well Health Center
3190 S. Wadsworth Blvd., Suite 240
Lakewood, CO 80227
303-934-3753 (office)
303-985-4673 (fax)
drconniend@aol.com
www.TheNutritionDoc.com

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?

_ Referral (name): ____

_ T. Colin Campbell site _ VegSource.com _ Whole Foods Market _ Vegetarian Society

_ John McDougall site _ Health Care Practitioner _ The Rave Diet site _ Lecture

_ Vitamin Cottage _ TheNutritionDoc.com _ Live Well Health Center

What are your three major health concern(s):

1. ____

2. ____

3. ____

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? ________

DIETARY PATTERN: Please check most applicable.
_Omnivore _Vegetarian _Lacto-ovo vegetarian (includes dairy & eggs)
_ Pescatarian (includes fish) _ flexatarian _Vegan (no animal products) _Raw
_ Fruitarian _ Nutritarian _ Paleo (high protein/low carb) _Low-fat/Low-carb
_ Other: ____________________________
If vegan, do you take a B12 supplement? Y N

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 KNOW 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** (if known)
Biological Mother			
Biological Father			
Brother(s) 1) 2) 3) 4)			
Sister(s) 1) 2) 3) 4)			
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			
Natural 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? ______
Are you satisfied with your weight? Y N, if no, explain: _________________________
____
Do you need to snack or eat frequently to avoid low blood sugar? 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 (low TSH)? 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 (autoimmune thyroid disease)? Y N Don't know
Have you ever been diagnosed with Hyperthyroidism (low TSH)? Y N
If yes, do you have Graves Disease (autoimmune thyroid disease)? Y N Don't know
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 type-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 (avoiding wheat, rye, barley, oats) ? Y N

Have you ever been exposed to pesticides, herbicides? Y N
Do you only purchase and eat organic foods? Y N Sometimes % organic ? _______
Have you had any other chemical exposure? Y N
If yes, which chemical? ____
Do you color your hair? Y N Do you wear cosmetics? Y N Scents? Y N

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*** ? _____________
Explain: ____
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? __________________________________
Did you breast feed? Y N

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 on mammograms or thermograms? 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
If yes, have you worked with, or are currently under the care of a
psychologist/counselor? Y N If yes, when? ______________

MALE REPRODUCTION

Do you have a problem with? Please check applicable symptoms and 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

If yes, are you working with, or have worked with in the past, as psychologist/counselor?

Y N If yes, how long ago? ________________

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

Do you take medications for the headaches? If yes, Rx/OTC dose/How often? _______

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   If yes, how often? __________________________
Do you have nose bleeds? Y N   If yes, how often? ____________________________

DENTAL
Have you ever had mercury fillings in your teeth? Y N
If so, how many? ________
Have you ever had your mercury fillings replaced? Y N
If yes, when? _________   With what? ______________________________________
Have you ever had a root canal? Y N
If yes, when? _________ How often? _______
Do you get canker sores inside 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** **Sarccoidosis**
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 (stinky)? 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*** ***or*** ***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 nervosa*** ***bulimia nervosa***

Have your ever been diagnosed with an eating disorder? Y N
If yes, did you receive treatment/or are you currently under treatment? Y N

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 sunscreen or sunblock? Y N
Have you ever had skin cancer? Y N If yes (circle): ***Basel cell (BCC)***
Squamous cell (SCC) Melanoma
Do you have any of the following skin problems (please circle***): Eczema Psoriasis***
Skin ulcers skin depigmentation (vitiligo) skin hyperpigmentation
itchy patches on skin dry scaly patches acne other _______________

Have you had a recent vitamin-D blood test? Y N
If yes, what was your level? _______________ How long ago? ___________
Are you currently taking vitamin D supplements? If yes, what is the dose? _____
Length of time taking ______________

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.

______________________________________ _______________
Signature Date

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