Insightful Wellness
Sherry@insightfulwellness.com
860-942-4334

Last Name_____

Nutrition Intake

Name: _____ Height: _____

Address: _____ Current Weight: _____ Ideal Weight: _____

_____ Date of Birth: _____ Age: _____

Home #: _____ _____

Work #: _____ Occupation: _____

Mobile #: _____ Referred by: _____

Email: _____ _____

Health objectives and conditions interested in addressing:

When did you first experience these health concerns? Did anything trigger or precede health condition?

Describe your diet when the condition started.

How have you addressed these conditions, currently and in the past *(doctor, self-care, nutrition, acupuncture) and what has been the impact (positive and/or negative)*?

What would you like to learn and gain from working with a nutrition consultant? *(i.e. how foods affect an ailment, understanding of how the body works, lifestyle improvement, meal ideas, etc.)*

Practitioner: _____ **Phone:** _____ **Email:** _____

Last Name_____

PERSONAL HEALTH HISTORY

What practitioners are you currently seeing? May I contact them with your permission?

Name	Specialty/condition	Phone	Permission

Describe your **health history as a child** *(healthy, frequently sick, ear infections, emotional trauma)*

Antibiotics: Describe how frequently you have taken antibiotics over the course of your life (as child, teen, and adult), *include long term use for acne and short-term courses*

Have you had any major life changes or losses (especially in the recent past or coinciding with the onset of illness)?

List current Medications (include condition, i.e. *Zoloft for depression*)

List current Supplements (or attach separate page). Mark those most effective with *
Important: Include form, dosage, and frequency (*i.e. calcium citrate, 400mg twice/day)*

Practitioner: _____ **Phone:** _____ **Email:** _____

Last Name_____

DIET

Are you on any of the following special diets?

- ❑ GFCF
- ❑ SCD/GAPS
- ❑ Paleo
- ❑ Autoimmune Paleo
- ❑ Feingold/Failsafe
- ❑ Body Ecology Diet
- ❑ Low oxalate
- ❑ Low FODMAPS
- ❑ Low Histamine
- ❑ Low Carbohydrate
- ❑ Ketogenic Diet
- ❑ Vegetarian
- ❑ Vegan
- ❑ No special diet

Which of the following foods do you have **allergies** or **food sensitivities**, and do you **currently avoid** them? Mark the following:

Serious Allergy	Sensitivity	Avoiding		Serious Allergy	Sensitivity	Avoiding	
❑	❑	❑	Gluten	❑	❑	❑	Others _____
❑	❑	❑	Dairy / Casein	❑	❑	❑	
❑	❑	❑	Soy	❑	❑	❑	
❑	❑	❑	Corn	❑	❑	❑	
❑	❑	❑	Eggs	❑	❑	❑	
❑	❑	❑	Sugar	❑	❑	❑	
❑	❑	❑	Chocolate	❑	❑	❑	
❑	❑	❑	Peanuts	❑	❑	❑	
❑	❑	❑	Citrus	❑	❑	❑	

How were the food sensitivities determined…. What type of allergy testing identified these allergens/sensitivities (skin/scratch, IgE/IgG, LEAP MRT, ALCAT, muscle testing, dietary elimination, known reaction, other)?_____

Last Name_____

If you **aren't gluten free currently,** do you suspect that you are:

Gluten sensitive _____ **Casein** sensitive _____ Explain _____

Have you ever tried eliminating gluten and dairy, and did you notice any effects?

_____

Do you have any significant food cravings? _____

Do you have any other dietary restrictions (purines, lectins, thiols/sulfur, etc.)?

_____

Describe your diet now_____

_____

DIET HISTORY

Please describe your experience with special diets *(i.e. how has your diet evolved, history of what diet changes made in the past, what gains you received, what symptoms did not improve)*

Date	Diet	Results, Notes, and Comments

Do you eat fish? How often and what type? _____

Do you eat sauerkraut? How often and what type? _____

Do you consume bone broth? How often and what type? _____

How much water do you drink per day? _____ What type (tap, bottled, filtered) _____

How often and how much wine, beer or alcohol do you consume? _____

Last Name_____

Do you consume:

- ❑ Coffee
- ❑ Caffeine
- ❑ Soda
- ❑ Diet soda
- ❑ Sweetened drinks
- ❑ Artificial sweeteners
- ❑ Trans fats
- ❑ MSG
- ❑ Canned soups
- ❑ Canned/boxes broths
- ❑ Non-organic GF packaged foods
- ❑ Non-organic meat, eggs or dairy
- ❑ Non-organic fruits and vegetables
- ❑ Non-organic corn, soy, canola, “sugar” (beet), papaya, summer squash

Do you have exposure to the following?

- ❑ Fluoridated water
- ❑ Chlorinated pools
- ❑ Chemical cleaning supplies
- ❑ Perfume/fragrance
- ❑ Fabric softener/drier sheets
- ❑ Tobacco

Do you have reactions to (consume large amounts/craves for) any of the following?

- ❑ Berries
- ❑ Apples/juice
- ❑ Grapes/raisins
- ❑ Bananas
- ❑ Honey
- ❑ Curry powder
- ❑ Spices/culinary herbs
- ❑ Medicinal herbs
- ❑ Wine
- ❑ Bone broth
- ❑ Sauerkraut
- ❑ Fermentations
- ❑ Soy Sauce
- ❑ Parmesan cheese
- ❑ Vegemite/Marmite
- ❑ Tomato sauce
- ❑ Artificial colors
- ❑ Artificial flavors
- ❑ Preservatives
- ❑ Sulfites
- ❑ Fragrance/perfume
- ❑ Aspirin
- ❑ Tylenol (acetaminophen)

Do you consume a lot of the following:

- ❑ Spinach
- ❑ Swiss chard
- ❑ Nuts
- ❑ Almond/almond flour
- ❑ Chia seeds
- ❑ Tahini
- ❑ Beans
- ❑ Soy
- ❑ Chocolate
- ❑ Black tea
- ❑ Amaranth
- ❑ Buckwheat
- ❑ Blackberries
- ❑ Figs
- ❑ Kiwi
- ❑ Beets

Practitioner: _____ **Phone:** _____ **Email:** _____

Last Name_____

ENERGY/MOOD/SLEEP

Have you been diagnosed or believe you may have hypoglycemia? _____

Do you need to eat frequently? _____

Do you get irritable, dizzy, headaches when you go too long without eating? _____

Fatigue _____

Depression _____

Anxiety _____

Stress level (1-10; 1 low and 10 high) and source_____

Occupation _____ Do you like your work? _____

How much sleep do you get _____

What time do you go to bed, to sleep, and wake up _____

Do you have trouble falling asleep _____

Do you wake in the night? What time? _____ Reason *(i.e kids, mind)?* _____

How long does it take to fall back asleep? _____

Do you feel tired after a full night sleep? _____

Body/Exercise

Recent weight changes (gained or lost)? _____

Do you want to change your weight? If so, how? _____

Amount/type of Exercise: _____

Do you feel energized or depleted after exercise? _____

Do you have a history of extreme dieting or eating disorders*? (i.e. Age, yo-yo dieting, calorie restriction)*_____

Women

Do you still have menstrual periods? _____

Number of days between cycles _____

Length of period _____

Are you pregnant? _____

Trying to get pregnant? _____

Are you nursing? _____

Number of children and ages _____

Do you have PMS, cramps, estrogen dominance, PCOS, or other? _____

Do you take hormones? _____

Practitioner: _____ **Phone:** _____ **Email:** _____

Last Name_____

Digestion and elimination

Do you have frequent gas? _____

Do you have bloating? _____

Does gas have a strong odor? _____

Do you tend to have diarrhea or soft, unformed stool? _____

Do you tend to have constipation? _____

Do you have burping, heartburn or acid reflux? Do you take antacids or acid blockers?

_____

Describe any other digestive issues? _____

_____

How frequently to you have a bowel movement? _____

What is consistency of stool?

- Formed like a brown banana _____
- Unformed, soft, or ribbon-like _____
- Small balls formed into banana, or “rabbit-pellets” _____
- Large diameter or anything else unusual _____

Toxic exposure:

Have you had exposure to any toxins (pesticides, chemicals, heavy metals, plastics, inhaled chemicals, industrial chemicals) that you are aware of at your home or office?

_____

Have you received any vaccinations including the flu shot?

_____

Are there any chemicals or smells that you are sensitive to (headaches, nausea)?

_____

Have you recently remodeled or plan to remodel your home? What did you have done?

_____

Infections and Toxins

Do you have any of the following....

- ❑ Lyme disease and co-infections
- ❑ Candida overgrowth (yeast infections, nail fungus, athlete’s foot)
- ❑ Viral infections: EBV, HVS, and others
- ❑ Clostridia or another gut pathogen
- ❑ SIBO
- ❑ Mold exposure and mycotoxins
- ❑ Exposure to water damaged building
- ❑ Glyphosate exposure
- ❑ Heavy metal toxicity

Last Name_____

FAMILY HISTORY

Common Familial Disorders

Please indicate any family history of the following and list family member affected, mark paternal or maternal with a "p" or "m" or SELF. For example: p-grandmother, m-aunt

Diabetes/Hypoglycemia _____ Colitis/IBS/IBD _____

Heart Disease _____Arthritis _____

Cancer _____Autoimmune disorder _____

Obesity _____Migraines/Headaches _____

Depression, anxiety _____Postpartum depression _____

ADHD, Autism, LD _____Bipolar, schizophrenia _____

Asperger's _____ Recurring yeast (vaginal, foot, etc.) _____

Hyperactivity, tics _____ Vulvadynia _____

Kidney stones _____ Sleep apnea _____

Alzheimer_____Multiple chemical sensitivity_____

Alcohol/chemical dependency_____ Fibromyalgia _____

Epilepsy/seizures_____ Chronic fatigue Syndrome_____

Rheumatoid arthritis_____ Asthma _____

Hashimoto's thyroiditis _____ Hypothyroid_____

Have you been diagnosed with…

Mitochondrial dysfunction _____

Impaired methylation_____

Mast cell activation syndrome_____

Share any gene SNPS results (or attach results). Include MTHFR, CBS, COMT, etc. and any health implications you've identified and any interventions you are using.

Remember to complete Symptom/Diet Checklist

Practitioner: _____ **Phone:** _____ **Email:** _____

Last Name_____

Food/Symptom Record

1. Please write out your daily diet. Fill out a diet record for at least two days. Include **portion size**, **beverages**, and any **supplements** or **medications**. Include **time** of day.
2. Additionally, record any symptoms you feel during or after eating, such as drowsy, irritable, etc.

MEAL	TIME	Food/Supplements	Mood/Energy/Symptoms
Example Only *Breakfast*	*9:00 am*	*1 cup of cereal with 3/4 c cow milk* *1 multi-vit/min, 500 mg vit C*	*9:00 Feel fine* *10:30 Low energy, stressed*
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Night-time/ Before bed			
Record sleep, elimination, and any other notes below...			

Practitioner: _____ **Phone:** _____ **Email:** _____

Last Name_____

Food/Symptom Record

1. Please write out your daily diet. Fill out a diet record for at least two days. Include **portion size**, **beverages**, and any **supplements** or **medications**. Include **time** of day.
2. Additionally, record any symptoms you feel during or after eating, such as drowsy, irritable, etc.

MEAL	TIME	Food/Supplements	Mood/Energy/Symptoms
Example Only *Breakfast*	*9:00 am*	*1 cup of cereal with 3/4 c cow milk* *1 multi-vit/min, 500 mg vit C*	*9:00 Feel fine* *10:30 Low energy, stressed*
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Night-time/ Before bed			
Record sleep, elimination, and any other notes below...			

Practitioner: _____ **Phone:** _____ **Email:** _____

Last Name_____

Food/Symptom Record

1. Please write out your daily diet. Fill out a diet record for at least two days. Include **portion size**, **beverages**, and any **supplements** or **medications**. Include **time** of day.
2. Additionally, record any symptoms you feel during or after eating, such as drowsy, irritable, etc.

MEAL	TIME	Food/Supplements	Mood/Energy/Symptoms
Example Only *Breakfast*	*9:00 am*	*1 cup of cereal with 3/4 c cow milk* *1 multi-vit/min, 500 mg vit C*	*9:00 Feel fine* *10:30 Low energy, stressed*
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Night-time/ Before bed			
Record sleep, elimination, and any other notes below...			

Practitioner: _____ **Phone:** _____ **Email:** _____