Client Intake Form

Personalize Nutrition by Tracey Long, MPH, RDN

Big Picture Health

Client Information

Your Name: | Today's Date:

Date of Birth: | Age: | Height: | Weight: | Sex: ☐ Male ☐ Female

Home Address: | Home Phone: | Messages okay? ☐ Y ☐ N

City, State, Zip: | Cell Phone: | Messages okay? ☐ Y ☐ N

Employer: | Work Phone: | Messages okay? ☐ Y ☐ N

Occupation: | Email Address:

Emergency Contact: | Phone: | Relationship to client:

Referring Provider: | May we contact your Provider about your case? ☐ Y ☐ N | Phone: | Fax:

Other providers:

Responsible Party Information (must complete if client under 18)

Name: | Date of Birth:

Home Address: | Home Phone:

City, State, Zip: | Cell Phone:

Work phone:

Are you (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? If yes, what ages?

At the present time, whom do you live with? (check all that apply)

☐ Alone ☐ Spouse/ Significant Other ☐ Children ☐ Relatives ☐ Group Setting ☐ Pets (type)

Ethnicity

☐ African American ☐ Hispanic ☐ Asian

☐ Native American ☐ Caucasian ☐ Other *(please note)*

☐ Mediterranean ☐ Northern European

ABO BLOOD TYPE *(check one)* ☐ **O** ☐ **A** ☐ **B** ☐ **AB** Have you ever had a blood transfusion? ☐ **Y** ☐ **N**

How did you hear my practice?

☐ Medical Professional ☐ Personal Recommendation ☐ Other

☐ Website ☐ Search EngineClient

Context of Care Review

The nature of your responses to the following questions will assist me in understanding of your background, desires and expectations.
Your time, thoughtfulness and honesty in completing this overview will greatly aid me in guiding your path to health.

COMPLAINTS/CONCERNS:

When was the last time you felt well?

Did something trigger a change in your health?

Describe your past attempts to reach your health goals (i.e. diets, programs, etc.)?

If you could erase three main health concerns, what would they be?

1.
2.
3.

What do you know about the functional and integrative approach to nutrition?

What 3 expectations do you have from this visit with Tracey?

1.
2.
3.

What long-term expectations do you have from working with Tracey?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocol which I will be sharing with you?

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

An Integrative approach often involves nutrition changes, adding key supplements, and some lifestyle changes. Please rate your willingness to add/ change the following with 1 being the least willing and 5 being the most willing to:

Significantly modify your diet	☐1 ☐2 ☐3 ☐4 ☐5	Adjust pre-sleep (bedtime) routine	☐1 ☐2 ☐3 ☐4 ☐5
Take several nutritional supplements	☐1 ☐2 ☐3 ☐4 ☐5	Have lab tests done to monitor progress	☐1 ☐2 ☐3 ☐4 ☐5
Engage in physical activity	☐1 ☐2 ☐3 ☐4 ☐5	Engage in stress-reduction strategies	☐1 ☐2 ☐3 ☐4 ☐5

How much on-going support and contact (e.g., telephone, e-mail) from Tracey would be helpful to you as you implement your personal health program?

Allergy Information

Food allergies: Reaction:

Non-food allergies: Reaction:

Medication allergies: Reaction:

PAST MEDICAL HISTORY: ***Please check all that apply to current or previous health history -- include dates.***

GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Reflux
- ☐ Gastric or Peptic Ulcer Disease
- ☐ Celiac Disease
- ☐ Hepatitis C or Liver Disease
- ☐ Other:

CARDIOVASCULAR

- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Irregular heart rate- pacemaker
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse/heart murmur
- ☐ Other:

SKIN

- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Shingles
- ☐ Other:

INFLAMMATORY/AUTOIMMUNE

- ☐ Chronic Fatigue
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Poor Immune Function
- ☐ Herpes-Genital
- ☐ Severe Infectious Disease
- ☐ Other:

METABOLIC/ENDOCRINE

- ☐ Diabetes: Type 1 or Type 2
- ☐ Metabolic Syndrome (Insulin Resistance)
- ☐ Hypoglycemia
- ☐ Hypothyroidism (underactive)
- ☐ Hyperthyroidism (overactive)
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Genetic Disorder
- ☐ Infertility
- ☐ Other:

NEUROLOGICAL

- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Autism
- ☐ Seizures
- ☐ ADD/ADHD
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Other:

RESPIRATORY

- ☐ Asthma
- ☐ Chronic sinus infections
- ☐ Allergies
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Other:

MUSCULOSKELETAL/PAIN

- ☐ Osteoarthritis
- ☐ Chronic Pain
- ☐ Joint Pain
- ☐ Fibromyalgia
- ☐ Other:

OTHER

- ☐ Kidney Stones
- ☐ Anemia
- ☐ Urinary tract infections
- ☐ Frequent yeast infections
- ☐ Other:

CANCER

- ☐ Cancer (please describe type and treatment)

PAST SURGICAL HISTORY: ***Please list any surgeries and dates of the surgery***

1.
2.
3.
4.
5.

MEDICATIONS:

Please list all **medications, vitamins,** and other **supplements WITH DOSAGES** you are currently taking (prescription or non-prescription). Please have them on hand for a phone or video chat appointment. Add any that don't fit below at the end of this document.

Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*
Name and dose:	*Reason:*

Have you had prolonged use of Tylenol or NSAIDS? If so, describe:

Have you had prolonged use of acid-blocking drugs (Prilosec, Zantac, Tagamet, etc.)? Include length of time.

Have you had frequent antibiotic use? Long-term antibiotic use?

Do you have a history of oral contraceptives? If yes, how long?

FAMILY HEALTH HISTORY: **Please list health history information for immediate family members (children, parents, grandparents, and siblings)**

Relationship	Living (Y/N)	Medical Condition(s)
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	

ENVIRONMENTAL HISTORY:

Occupation: Spouse Occupation:

Please list any regular or past exposure to harmful chemicals or substances:

Do you have regular exposure to any of the following:

- ☐ Cigarette Smoke
- ☐ Heavy Metals
- ☐ Paint fumes
- ☐ Auto exhaust/fumes
- ☐ Teflon/aluminum Cookware
- ☐ Mold
- ☐ Dry-cleaned clothes
- ☐ Pet dander
- ☐ Pesticides
- ☐ Nail polish/hair dyes
- ☐ Perfumes
- ☐ Fertilizers

BIRTH HISTORY:

Were you born term or preterm?

Were you born vaginally or C-section?

Were you breastfed or bottle fed?

DENTAL HISTORY:

Do you have any silver/amalgam fillings? If yes, how many?

Do you visit a dentist regularly (twice per year)?

Do you have any of the following?:

☐ Tooth pain ☐ Bleeding gums ☐ Root canals ☐ Chewing pain

Lifestyle Information

Do you smoke? ☐ Y ☐ N If so, how many years? How many packs per day?

2nd hand smoke exposure? ☐ Y ☐ N

Excess stress in your life? ☐ Y ☐ N Easily handle stress? ☐ Y ☐ N

Daily Stressors: *Rate on a scale of 1 (low) to 10 (high)*

Work Family Social Finances Health Other (explain)

Do you feel your life has meaning and purpose? ☐ Y ☐ N ☐ unsure

Do you believe stress is presently reducing the quality of your life? ☐ Y ☐ N

Average number of hours you sleep per night **during the week**?

Average number of hours you sleep per night **on weekends**?

Do you have trouble falling asleep? ☐ Y ☐ N

Are you rested upon waking? ☐ Y ☐ N

Do you wake up during the night? ☐ Y ☐ N If yes, how many times?

Note the approximate times you generally wake during the night.

How would you rate the overall quality of your sleep? ***low quality*** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ***high quality***

EXERCISE BEHAVIORS

Describe your daily activity level and exercise program:

Estimate how many hours per day you sit?

NUTRITION HISTORY:

Height	Current Weight	Usual Weight (+/- 5 lbs)	Highest Adult Weight	Lowest Adult Weight	Desired weight	Body Fat %

Have you ever had a nutrition consultation? If yes, what do you remember from the consultation or what did you learn?

Have you made any eating changes for your health?

How many meals do you eat per day? Which meals?

Do you avoid any particular foods? If yes, describe types and reason.

How often do you weigh yourself?

If you could only eat a few foods per week what would they be?

Do you grocery shop?

Do you know how to prepare your own food at home?

How many meals do you eat out per week?

What are the top 3 dietary changes you think would make the most difference in your health?

1.
2.
3.

Do you currently follow any special nutrition program or plan? *Check all that apply*

- ☐ Low-Fat
- ☐ Low-Carb
- ☐ High-Protein
- ☐ Low-sodium
- ☐ Vegetarian
- ☐ Vegan
- ☐ Dairy-Free
- ☐ Gluten-Free
- ☐ Diabetes (carb control)
- ☐ Calorie Controlled
- ☐ Specific wt loss program
- ☐ Other

Check the following that apply to your current lifestyle and eating habits:

- ☐ Fast eater
- ☐ Erratic Eating patterns
- ☐ Eating too much
- ☐ Emotional eater
- ☐ Late night eating
- ☐ Dislike healthy food
- ☐ Time Constraints
- ☐ Confused about nutrition
- ☐ Frequent travel
- ☐ Do not plan
- ☐ Rely on convenience foods
- ☐ Frequently eat fast foods
- ☐ Love to eat
- ☐ Family members w/ different likes
- ☐ Poor snack choices
- ☐ Negative food relationship

DIGESTION:

Do you feel like belching or are you bloated after eating?

Do you have a history of any eating disorders? If yes, please describe.

Bowel movements:

How often?
Color?
Consistency?
Float or sink?

How do you react to caffeine? (wired or not affected or affect lasts for hours):

Please indicate how often you eat/drink the following PER WEEK:

____ Soda (regular/diet)	____ Fast food	____ Fruit (can/dried)
____ Alcohol	____ Prepared meals (Lean cuisine, etc.)	____ Fruit (fresh/frozen)
____ Hot/cold tea	____ Processed meats	____ Raw veggies/salads
____ Coffee (regular/decaf)	____ Restaurant meals	____ Cooked veggies
____ Sweetened drinks	____ Crackers	____ Potatoes
____ Purified water	____ Pasta	____ Popcorn/corn
____ Tap water	____ Rice	____ Cereals
____ Fruit juice	____ Tortillas	____ Oatmeal
____ Lemonade	____ Chips	____ Bagels/pretzels
____ Milk (cow/goat)	____ Pizza	____ Bread

_____ Milk (soy/rice/nut)
_____ Yogurt
_____ Cheese
_____ Ice cream
_____ Jelly/jam
_____ Candy/sweets
_____ Artificial Sweeteners (splenda, equal, sweet and low)
_____ Red meat
_____ Beans, lentils
_____ Fish(tuna/salmon/sushi)
_____ Whole eggs
_____ Tofu/Tempeh/Miso
_____ Poultry

Please list and describe a typical daily eating routine.

Time	Location/activity	Food/Beverage	Amount (cup, oz, etc)	Mood	Symptoms
Example: 8 am	*Home/Breakfast*	*Eggs, banana with peanut butter*	*2 large eggs, ~2 Tbsp PB*	*Satisfied*	*Bloated*

FATS AND OILS SURVEY

Please indicate how many times PER WEEK you consume the following fats/oils.

OMEGA 9

- ☐ Almond Oil
- ☐ Almonds/cashews
- ☐ Almond butter
- ☐ Avocados
- ☐ Avocado Oil/Mayo
- ☐ Peanuts
- ☐ Peanut butter (natural)
- ☐ Olives
- ☐ Olive Oil
- ☐ Sesame Seeds/Tahini
- ☐ Hummus
- ☐ Macadamia Nuts
- ☐ Pine Nuts
- ☐ Pistachios

OMEGA 6

- ☐ Eggs (whole)
- ☐ Meats (commercial)
- ☐ Meats (organic, grass fed)
- ☐ Brazil nuts (raw)
- ☐ Pecans (raw)
- ☐ Hazelnuts (raw)
- ☐ Hemp Seeds
- ☐ Evening Primrose Oil
- ☐ Black Currant Oil
- ☐ Borage Oil
- ☐ Hemp Oil
- ☐ Grapeseed Oil
- ☐ Sunflower seeds (raw)
- ☐ Pumpkin seeds (raw)

OMEGA 3

- ☐ Fish Oil supplement:
- ☐ Fish (salmon/fin-fish)
- ☐ Fish (shellfish)
- ☐ Flaxseed (ground)
- ☐ Flax Oil
- ☐ Algae
- ☐ Greens Powder w/ algae
- ☐ Chia seeds
- ☐ Walnuts

BENEFICIAL SATURATED FATS

- ☐ Coconut Oil
- ☐ Canned coconut milk
- ☐ Butter (organic)
- ☐ Ghee/clarified butter
- ☐ Dairy (organic)
- ☐ Meats (grass-fed)
- ☐ Wild Game
- ☐ Poultry (organic)
- ☐ Eggs (whole, organic)

DAMAGED FATS/OILS

- ☐ Margarine
- ☐ Vegetable oils (corn, sunflower, canola)
- ☐ Mayonnaise (commercial)
- ☐ Imitation Cheeses
- ☐ Tempura
- ☐ Hydrogenated oil (listed as ingredient)
- ☐ Doughnuts (fried)
- ☐ Deep fried foods
- ☐ Chips (fried)
- ☐ Regular salad dressing
- ☐ Peanut butter (JIF, etc)
- ☐ Roasted nuts/seeds
- ☐ Non-dairy products

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

Name: _____ Date: _____

This questionnaire helps us identify the underlying cause of illness and allows us to track your progress over time.
Please rate each of the following symptoms based on your health profile over the past:

☐ Past 30 days (if first time completing MSQ) ☐ Past 48 hours (if completing a follow-up MSQ)

POINT SCALE:
0 – Never or almost never have symptoms
1 – occasionally have it, not severe
2 – occasionally have it, severe
3 – Frequently have it, not severe
4 – Frequently have it, severe

HEAD
- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness
- ☐ Insomnia
- ☐ **Total**

HEART
- ☐ Irregular/skipped beats
- ☐ Rapid/pounding beats
- ☐ Chest Pain
- ☐ **Total**

ENERGY/ACTIVITY
- ☐ Fatigue/sluggishness
- ☐ Apathy, lethargy
- ☐ Hyperactivity
- ☐ Restless leg
- ☐ **Total**

EYES
- ☐ Water/itchy eyes
- ☐ Swollen, red/sticky eyelids
- ☐ Bags, dark circles
- ☐ Blurred/tunnel vision
- ☐ **Total**

LUNGS
- ☐ Chest congestion
- ☐ Asthma, bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ **Total**

MIND
- ☐ Poor memory
- ☐ Confusion, poor comprehension
- ☐ Stuttering/stammering
- ☐ Poor coordination
- ☐ Difficulty making decisions
- ☐ Slurred speech
- ☐ Learning disabilities
- ☐ **Total**

EARS
- ☐ Itchy ears
- ☐ Earaches, infections
- ☐ Drainage from ear
- ☐ Ringing/ hearing loss
- ☐ **Total**

DIGESTIVE TRACT
- ☐ Nausea, vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Belching, passing gas
- ☐ Intestinal/stomach pain
- ☐ Heartburn
- ☐ **Total**

EMOTIONS
- ☐ Mood Swings
- ☐ Anxiety, fear, nervousness
- ☐ Anger, irritability, aggressiveness
- ☐ Depression
- ☐ **Total**

NOSE
- ☐ Stuffy Nose
- ☐ Sinus Problems
- ☐ Hay Fever
- ☐ Sneezing attacks
- ☐ Excessive Mucous
- ☐ **Total**

MOUTH/THROAT
- ☐ Chronic coughing
- ☐ Gagging/ throat clearing
- ☐ Sore throat, hoarseness
- ☐ Swollen/discolored tongue, gums, lips
- ☐ Canker sores
- ☐ **Total**

JOINTS/MUSCLE
- ☐ Pain or aches in joints
- ☐ Arthritis
- ☐ Stiffness/limited movement
- ☐ Pain/aches in muscles
- ☐ Feeling of weakness or tiredness
- ☐ **Total**

SKIN	WEIGHT	OTHER
☐ Acne	☐ Binge eating/drinking	☐ Frequent illness
☐ Hives, rashes, dry skin	☐ Craving certain foods	☐ Frequent or urgent urination
☐ Hair loss	☐ Excessive weight	☐ Genital itch or discharge
☐ Flushing, hot flashes	☐ Compulsive eating	☐ **Total**
☐ Excessive sweating	☐ Water retention	
☐ **Total**	☐ Underweight	
	☐ **Total**	☐ **MSQ TOTAL**

Reviewed by: _____ Date: _____

Thank you for taking the time to complete this before your appointment. Please email or mail this form to me so I have it at least two business days before your appointment. This will allow me time to review your history so we can focus on you and your plan instead of using your appointment time to fill in this information.

Email to: tracey@bigpicturehealth.com (be certain to fill in all blanks and save the document before attaching to an email)

Mail to: Tracey Long, MPH, RDN
1046 Carousel Ln
Hendersonville, NC 28792

Thank you for trusting me to be part of your healthcare team.

Tracey

Use this space for any additional information you would like me to know or to supplement your response to any question on the intake form.