Nutrition Counseling Intake Form

First Name (Last, First, Middle) _____ Date_____

Occupation? _____How many hours a week do you work? _____ Commute? _____

Phone _____ Email _____

Address_____

Age_____ Date of Birth_____ Height_____ Weight_____

Marital Status_____ Children? _____

Ethnic Background/Birthplace_____

Please list your chief health intentions that you would like to improve, physical or emotional.

1-_____

2-_____

3-_____

4-_____

Women's Health

Period: Regular? _____ How many days is your flow? _____ How frequent? _____

Heavy? _____ Light? _____ Painful? _____ Clotted? _____ PMS? _____ Spotting?

Vaginal discharge? _____Yeast infections? _____ Miscarriages? _____Abortions? _____

Western Diagnosis? _____

Current TCM Diagnosis? _____

Acupuncturist _____

Describe any pain, stiffness or swelling in your body? ____ If yes, where? _____

Are you prone to headaches? _____ dizziness? _____ Mucus issues? _____

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Is your urine clear like water? ___ turbid or cloudy?___ scanty?___ yellow?___

dark yellow? ___

Do you have root canals? ___ If so, how many? ___ Were you breast fed? ___

If yes for how many months?_____

How is your digestion? Loose stools? _____ Constipation? _____ Bloating? _____

1) Favorite colors, seasons, and flavors [bitter, sweet, salty, pungent or hot, sour]:

2) Aversions to what colors, seasons, and flavors [bitter, sweet, salty, pungent or hot, sour]:

Please circle any conditions you tend toward or are currently experiencing:

forgetfulness	overweight	asthma	dry mouth	allergies/ hayfever
intense dreams	underweight	bronchitis	hearing loss	highly emotional
insomnia	indigestion	immune weakness	ringing in ears	bloating
restless sleep	intestinal gas	frequent colds/flus	low back pain	eye/visual problems
speech problems	diarrhea	frequent cough	dizziness	morning stiffness
confusion	constipation	skin eruptions	teeth problems	stiff neck
palpitations	weak muscles	rash/fungus	low sex drive	muscular pain
chest pains	prolapses	dry skin	knee problems	anger/ impatience
memory loss	appetite disorder	grief/sadness	aversion to cold	swellings
heart trouble	sugar craving	irritable colon	urinate often	dry/red eyes
poor circulation	hemorrhoids	shortness of	fear/insecurity	high blood press.
lack of spirit	fatigue	breath	ear infections	vertigo
joyless	worry	perfectionist	drug addiction	mood swings
spaciness	water retention	congestion	arthritis	headaches
lack of focus	ulcers	excess mucus	bone problems	depression
addictions	mouth sores	fatigue/lethargy		stress/tension

often too warm	cancer/tumors	frequent thirst	often too cold	cramps/ spasms
yellow mucus	cysts/warts	night sweats	clear mucus	paralysis/ tremor
dry stool	yeast infection	hot palm/feet	loose stools	moving pains
dark urine	dislike dampness	Tidal fevers	clear urine	dislike wind

Do you sleep soundly? _____ How many hours per night? _____ Have lots of dreams? _____

Do you wake in the night? _____ If yes, what time? _____

How are your **emotions?** Excess? _____ Depression? _____Unresolved resentments? _____

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Other emotional issues:

Please list any awareness practices (calming practices: prayer, meditation, affirmation)?

Describe your daily physical exercise routine:

List any herbal, vitamin or other supplements you are currently taking:

Do you have any allergies to food or medications? Please list.

Do you generally have enough **energy**?

Is your **appetite** good?

Do you feel sluggish after eating?

Do you have a big **thirst**? ___ Small but frequent thirst? ___ Little or no thirst? ___

Like ice water? ___

Describe Current Diet

Time on current diet?_____ organic %_____Eat late at night?_____

What percentage of your food is home-cooked? _____

Where do you get the rest from? _____

Drink with meals? _____ If so, what and how much? _____

Please indicate if you consume the following (O)ften, (S)ometimes or (N)ever:

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Coffee?____ Alcohol?_____ Tobacco? _____ Marijuana? _____ Baking powder? _____ Yeasted bread? _____

Margarine? _____ Shortening? _____ Commercial Donuts, pastries, candy, pop? _____ Chocolate? _____

Ice cream? _____ Foods with white flour, white sugar, white rice, white pastas? _____ Deep fried

foods? _____ Dairy? _____ Meat? _____ Legumes? ____ Sea vegetables? _____ Fruit? ____ Vegetables?_____

Types of oils used_____

Do you chew your food thoroughly?_____

How much **water** do you drink daily? _____ List all other beverages including rice milk or almond milk, tea, herbal teas, soymilk, etc.:

What's your food intake like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Foods you love/ crave?

Foods you dislike?

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