PATH OF LIFE HEALING CENTER

Healing | *Detoxification* | *Wellness*

☐ MEDICAL NUTRITION THERAPY ☐

ADULT INTAKE QUESTIONNAIRE

NUTRITION COMPLIANCE

Client confidentiality will be maintained at all times. The information provided on this questionnaire may only be disclosed with the express written consent of the individual named herein or, if under the age of 18, his or her legal guardian.

INSTRUCTIONS FOR YOUR FIRST NUTRITION CONSULTATION:

Thank you for taking the time to answer the questions in this new client questionnaire thoughtfully. You will have many opportunities to address any concerns that require more detail during your appointment with your Licensed Integrative Clinical Nutritionist.

CONSENT TO PATH OF LIFE HEALING CENTER SERVICES

I, ____________________________________, understand that Path of Life Healing Center is providing nutritional counseling and dietary supplements: recommending use of foods, diet plans, or dietary supplements. dietary supplements include plants/botanicals, minerals, vitamins, amino acids, and animal materials; may be in the form of teas, pills, powders, tinctures (may contain alcohol), topical applications, suppositories, hydrotherapy, and spa services.

Potential Risks: I understand that, while not common, side effects can potentially occur from herbal medicines and dietary supplements. Some examples include, but are not limited to: headaches, skin rashes, digestive upset, or less commonly, allergic reactions to recommended herbs or supplements. Nutritional evaluation or testing provided in Nutritional Counseling is not intended for the diagnosis of disease. Rather, these evaluations are intended as a guide to developing an appropriate health-supportive program for me, and to monitor my progress in achieving my goals.

Use of De-identified Health Information in a workshop/seminar Setting: Path of Life Healing Center is engaged in educating faith-based and secular communities on health promotion and preventive care. The community can benefit from rich discussions, observations, and protocols that work for others. As a client in Path of Life Healing Center, your successes in health improvement contributes to the growth and future development of the community. I understand that my health information may be **de-identified and used** in a community setting for teaching purposes only. **No information will be shared that will identify me or otherwise compromise my protected health information.** I understand that I have the right to **initial below to opt-out** of allowing my case to be presented.

______ By initialing this line, I hereby do not give my consent to use my case in a community/seminar setting.

Voluntary: I hereby request and consent to receive Path of Life Service(s) as indicated above. **I have not been guaranteed any specific outcomes concerning the uses and effects of any Path of Life Services.** I understand that I am free to discontinue any or all Path of Life Services at any time. **I voluntarily assume all risks** inherent in the nature of each of the Path of Life Services. I waive all claims, costs, liabilities, expenses and judgments against Path of Life Healing Center in association with Vee Lazuli, Inc and release staff members, officers, agents, representatives, and employees from all claims, costs, liabilities, expenses, and judgments arising out of Path of Life Healing Center.

Cancellation Policy: I have been informed of the fees for service, and I understand that payment is due when the services are provided. If I do not cancel an appointment at least 24 hours in advance, then I am liable for a fee (TBD). **Fees for Returned Checks and Late Payments:** I understand that I am liable for a returned check fee, in addition to any fees owed for services. **I may also be liable for any difference in service fees that are not paid in full** at the time of service. Any fees for service not paid at the time of service or within thirty (30) calendar days may incur a late fee.

Signed: ____

Please Send Lab results with Your Intake Forms if you have them:

1. Please send any lab work prior to your visit if possible. Include any lab test results, allergy, blood, hormonal, stool, or other pertinent medical information you think may be helpful.

Please bring the following with You:

- Any pharmaceuticals, over-the-counter drugs, and/or supplements you are taking – please bring them in their original containers so your nutritionist can determine what ingredients and amounts are in the products.

YOU HELP US HELP YOU WHEN YOU SEND BACK YOUR COMPLETED FORM 1 WEEK PRIOR TO YOUR APPOINTMENT!

Please allow 30-45 minutes to complete this questionnaire. The 3-day diet diary will require you to record your food and beverage intake over a 3-day period. The food frequency chart takes time. Please answer the questions below as thoroughly as possible so that we may make the best possible clinical assessment. This helps us develop a realistic and workable plan for supporting you in reaching your health goals. Your answers to personal questions such as relationship status, religion, parental history, physical history, etc. are important as they provide helpful context for establishing a productive partnership with you, possible epigenetic linkage, and neurotransmitter messaging to your current health challenges. That said; please answer only the questions you are comfortable answering. However, all the information we are seeking helps us understand your body and helps you achieve results.

Name (Last, First M.I.): ____ Physical Address: ____ ____	Consultation Date: _________________________ Allergies: ______________________ ______________________________ ______________________________
Email Address: ____ Cell Phone: #____ Health Insurance: YES | NO: Insurance Info filled out and attached: YES | NO HIPPA Privacy Act ____ Authorization to Bill Insurance Co. ____ Superbill ___	Reason for Visit-if Different from Reason for Referral/Diagnosis: ______________________________ ______________________________ ______________________________
PHYSICIAN INFORMATION	
Doctor's Name: ____ Telephone Number: ____ Office Address: ____ Email Address: ____ Fax Number: ____	Date Last Seen Doctor: ___________________ Date Last Physical Exam: _________________
Is this Nutrition Visit a Referral? YES | NO Reason for Referral/ Diagnosis? ____ ____	May We Contact Your Referring Doctor? YES | NO Telephone Number: ________________________

EMERGENCY CONTACT					
Name:		Relationship:		Phone:	

OCCUPATION & INTERESTS					
Occupation:		How long?		Satisfied? (1-10)	
What are your interests/passions?					

DEMOGRAPHICS									
Age		Date of Birth		Gender		Race		Ethnicity	
Height:		Weight	lbs.	Highest Adult Weight	lbs. / Yr.:	Lowest Adult Weight	lbs. / Yr.:		

RELATIONSHIP INFORMATION					
Status		Partner's Name:		Partner's Gender:	

PERSONAL INFORMATION			
Religion:		Education:	
With whom (persons or animals) do you share your home?			

What types of health practitioners are you currently working with?

What are your primary reasons for coming to your nutrition intern?

1.

2.

3.

Notes: ____

____

____

____

____

____

Medical Information

What health concerns did you experience as a child?

What health concerns have you experienced as an adult?

Has your doctor diagnosed you with a medical condition (s)? If so, please list:

Are you part of a recovery program? If so, which one?

Do you have any allergies to foods, medications, chemicals, and/or other environmental substances?
If so, to which ones?

What is your typical reaction and how severe is it (1-10)?

What, if any, surgeries/operations have you undergone, and when?

Have you ever been hospitalized for reasons other than surgeries/operations?
If so, when and for what reason(s)?

Have you ever had a major chemical exposure? If so, when and to what?

Where and when have you lived or traveled outside of the U.S. and Canada?

Is there anything that surfaced during a recent medical test, lab work, or doctor's visit that you would like to report?

Describe your antibiotic use. How often and for what conditions? (Any use that extended past 1 week)

Family History

RELATIONSHIP	ALIVE/DECEASED	PRESENT HEALTH OR CAUSE OF DEATH
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brothers		
Sisters		
Children/ages		

For Women

PREGNANCIES *(PLEASE INCLUDE LOSSES/TERMINATIONS)*			
Year	Vaginal/C Section	Sex	Complications/Other Things You Want to Mention

Are you currently pregnant? Are you actively trying to conceive? Are you breastfeeding?

PHYSICAL ACTIVITY					
	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Active lifestyle					Examples?
Cardio type exercise					What type(s)?
Strength building exercise					What type(s)?
Stretching					What type(s)?
How would you categorize your activity level?		Sedentary Mildly Active Moderately Active Very Active Intensely Active			

SLEEP	
At what time are you typically in bed?	
What time do you fall asleep?	
Typical hours asleep?	
# of times you awaken during the night	
Reason(s) why you wake during the night	
Do you feel rested upon rising?	

LIFESTYLE					
	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Sexual Activity					
Socializing w/Friends					
Relaxation/Self Pampering					What type(s)?
Tobacco					What type(s)?
Recreational Drugs					What type(s)?
Teeth Flossing					

STRESS							
On a scale of 1-10, with 1 being low and 10 being high, how stressful is your:							
Work:		Social/family situation:		Current health status:		Life in general:	
Do you feel that your current state of health is:			largely in your control or largely out of your control				
What do you believe you can do to make a difference in your current health status?							
If so, what 1-2 key steps have you already taken?							

Significant Moods				
☐ accepting	☐ anxious or nervous	☐ angry	☐ capable	☐ compassionate
☐ determined	☐ dreadful	☐ empowered	☐ enthusiastic	☐ fortunate
☐ guilty	☐ happy	☐ hopeful	☐ hurt	☐ inspired
☐ lonely	☐ loved	☐ peaceful	☐ resentful	☐ resigned
☐ sad	☐ scared	☐ terrified	☐ tired	☐ uncertain

Significant Life Events	
Please list major events in the last ten years of your life and the dates they occurred. Include illness, medical condition, births, deaths, marriage, divorce, accidents, moves, jobs changes, miscarriages, and anything else you feel greatly impacted your life.	
Date	Event

MEDICATIONS AND SUPPLEMENTS

CURRENT MEDICATIONS | HERBAL AND VITAMIN SUPPLEMENTS				
Name	Dosage	Frequency	Length of Time	Reason for Taking
What medication have you taken in the past for a considerable amount of time?				

METABOLIC SCREENING QUESTIONNAIRE

Use this questionnaire to chart your health and progress. Rate each of the following symptoms based on your health for the past thirty days.

Point Scale:
O = Never or almost never have the symptom.
1 = Occasionally have it; effect is not severe.
2 = Occasionally have it; effect is severe.
3 = Frequently have it; effect is not severe.
4 = Frequently have it; effect is severe.

The Medical Symptom Questionnaire was developed by Jeffrey Bland, PhD.

Digestive Tract
_____ Nausea or vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching or passing gas
_____ Heartburn
[ ] **Total**

Ears
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
[ ] **Total**

Emotions
_____ Mood swings
_____ Anxiety, fear, or nervousness
_____ Anger, irritability or aggressiveness
[ ] **Total**

Energy/Activity
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
[ ] **Total**

Eyes
_____ Watery or itchy eyes
_____ Swollen, reddened, or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
_____ Slurred speech
[ ] **Total**

Mouth/Throat
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores
[ ] **Total**

Nose
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
[ ] **Total**

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
[ ] **Total**

Heart
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest Pain
[ ] **Total**

Joints/Muscles
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation in movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
[ ] **Total**

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
[ ] **Total**

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Learning disabilities
[ ] **Total**

Skin
_____ Acne
_____ Hives, rashes, or dry skin
_____ Hair Loss
_____ Flushing or hot flashes
_____ Excessive sweating
[ ] **Total**

Weight
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
[ ] **Total**

Other
_____ Unexplained itching
_____ Use aluminum
_____ Fast food > 2x week
_____ Use Microwave
_____ Amalgam silver fillings
_____ Rarely sweat
_____ Exposure to chemicals
_____ Low water intake
_____ Inactive lifestyle
_____ Poor sleep quality
_____ Medium to high stress
_____ Use alcohol or tobacco
_____ Frequent illness
_____ Frequent or urgent very dark urination
_____ Genital itch or discharge
[ ] **Total**

[ ] **Grand Total**

SYMPTOM QUESTIONNAIRE Please place **yes or no** after each question.

Section 1	
Indigestion, burping, bloating or sleepy immediately after meals	
Heartburn or acid reflux symptoms	
Tendency to allergies, eczema, asthma	
Nausea in evenings	
Proteins hard to digest, complex meals hard to digest (combination of proteins and carbs)	
Loss of taste for meat	
Sense of excess fullness after meals	
Feel like skipping breakfast, overall low appetite	
Undigested food in stool	
Anemia, unresponsive to iron	

Section 2	
Heartburn or acid reflux symptoms	
Nausea in mornings	
Strong appetite, demanding hunger, excess salivation	
Aggravated by spice or sour, sour burps, sour smell	

Section 3	
Pain between shoulder blades	
Stomach upset by fatty or fried foods	
Loose stools with fatty foods, irregular stools, fat in stools (shiny, floating), smelly stools	
Nausea	
Light, clay colored or greenish/yellow stools	
Dry skin, itchy feet or skin peels on feet	
Gallbladder attacks	
Gallbladder removed	
Bitter taste in mouth, especially after meals	
Easily intoxicated or hung if you were to drink wine	
Pain under right side of rib cage	
Hemorrhoids or varicose veins	
Sensitive to chemicals (perfume, cleaning agents, etc.), diesel fumes or tobacco smoke	

Section 4	
Food allergies or sensitivities (wheat or grain, or dairy or other)	
Frequent intake of allergenic food (s), strong attachment to allergenic foods	
Craving, addiction or binging of allergenic foods (s)	
Abdominal bloating 1-2 hours after eating	
Pulse speeds up after eating	
Crohn’s disease, frequent sinus infection, migraines, asthma	
Airborne allergies	
Experience hives	

Section 5	
Catch colds at the beginning of winter	
Frequent colds, flu or other infections (sinus, ear, bladder, skin, etc.)	
Experienced a mucous producing cough	
Never get sick	
History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis, or other chronic viral conditions	
Have food allergies or sensitivities	

Section 6	
Coating on your tongue	
Anus itches	
Fungus or yeast infections	
Yeast symptoms increase with sugar, starch or alcohol consumption	
Less than one bowel movement a day	
Constipation, stools hard or difficult to pass	
Excessive foul smelling lower bowel gas	
Irritable bowel or mucous colitis	
Bad breath or strong body odor	
Cramping in lower abdominal region	
Stools are difficult to pass	
History of parasites	
Stools have corners or edges, are flat and ribbon shaped	

Section 7	
Eat less than five servings of (one-half cup cooked, 1 cup raw) of colored vegetables or fruits a day	
Crave sweets, breads, rolls, cookies, pasta, pizza or chips	
Crave coffee or sugar in the afternoon	
Sleepy in the afternoon	
Fatigue is relieved by eating	
Binging or uncontrolled eating	
Excessive appetite	
When you eat snacks/sweets, do you eat them, get a temporary boost of energy and mood, and later crash?	
Headache, irritability or shakiness if meals are skipped or delayed	
Heart palpitations after eating sweets	
Have frequent thirst	
Have frequent urination	
Once you start eating sweets or carbohydrates, do you feel you can’t stop	
Tend to gain weight in the belly	
Have pre-diabetes, diabetes, PCOS, hypoglycemia or alcoholism or a family history of any one of these	
Have elevated triglycerides or cholesterol	
Have high blood pressure	

Section 8	
Have high or low blood pressure	
Have a low libido	
Have trouble falling asleep	
Get less than 8 hours a sleep a night	
Go to bed frequently after midnight	
Get less than 1 hour a day of sunlight	
Work the night shift	
Are you an emotional eater	
Feel anxious or have panic attacks	
Are you a shallow breather	
Experience heart palpitations	
Cravings for salt or sweets	
Experience chronic or prolonged fatigue	
Does fatigue prevent you from doing things you would like to do. Interfere with you work, family or social life	
Do you feel you can’t get started in the morning without coffee or caffeinated drinks	

Section 9	
Are you cold when everyone else is warm	
Have course or brittle hair	
Experience constipation	
Have thinning hair or hair loss	
Experienced a loss of sex drive	
Lost the outside of your eyebrow	
Experience depression	
Have trouble losing weight	
Have a low blood pressure or heart rate	
Have elevated cholesterol	
Have a hoarse voice	
Have dry, scaly skin	
Have cold hands and feet	
Experience fatigue	
Experience fluid retention	

Section 10	
Aware of irregular or heavy breathing	
Experienced discomfort at high altitudes	
Sigh frequently or “air hunger”	
Have shortness of breath with moderate exertion	
Experience swelling of the ankles, especially at end of day	
Blush or face turns red for no reason	
Experience a dull pain or tightness in chest and/or radiate into left arm, worse on exertion	
Have muscle cramps on exertion	

Section 11	
Rarely break out into a sweat	
Use aluminum cooking equipment	
Have mercury amalgams	
Heat food in plastic containers in microwave	
Have your clothes dry-cleaned	
Eat “fast-food” > 2 times a week	
Drink tap, well or bottled water	
Have strong body odor	
Have acne on face or buttocks	
Drink < 4 cups water a day (approximately 30 oz)	
Live in a large urban or industrial area	
Use lawn or garden chemicals	
Have less < 1 bowel movement per day	
React to small amounts of alcohol	
Sit on your computer 3+ hours a day	
Exercise < 3 times a week	
Use tobacco products	
Eat large fish (sword fish, tuna, shark, tilefish) more than once a week	
Urinate small amounts of dark urine only a few times a day	
Frequently exposed to solvents and chemicals at work or at home	
Feel any of the following: wired, increased aches in muscles and joints, anxiety, palpitations, sweating, dizziness when using caffeine	
Have a negative reaction when you consume foods containing MSG, sulfites or other preservatives	

SPECIAL DIETARY INTAKE INFORMATION:

If you follow a special diet/nutritional program, check the following that apply:

Low Fat	Low Carb	High Protein	Low Sodium	No Gluten	Vegetarian	Vegan
Diabetic	No Dairy	No Wheat	Weight Loss	Other ____________________		

Which meals do you eat regularly, check all that apply:

Breakfast (________) Lunch (_________) Dinner/Supper (________) Snacks (time ________)

If I could change three things about my health and nutritional habits, they would be...

1.____

____

2.____

____

3.____

____

Reactions (physical/mental) I have to certain foods that may or may not be an allergic reaction:

____

____

____

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals...

____

____

____

EATING STYLE: BASED ON HOW YOU EAT ON A REGULAR BASIS, PLEASE CHECK ALL THAT APPLY:

Fast Eater	Erratic eater	Love to eat
Eat too much	Late night-eater	Time constraints
Eat because I have to	Dislike “healthy” food	Struggle with eating issues
Travel frequently	Poor snack choices	Confused about food/nutrition
Do not plan meals/menus	Rely on convenience items	Negative relationship with food
Frequently eat fast food	Emotional eater (stressed, bored)	

Food cravings that I have: ____

____

Foods I do not like: ____

____

DIETARY HABITS

24 Hour Dietary Recall

Please take the time to itemize the meals as shown above, so that I may be able to analyze the caloric intake. This step will help me to understand your appetite and choices, so I can properly guide you.

Mealtimes: Time You Eat	**Food Item (Eat or Drink)**	**Portion Size (Cup, Spoon)**	**How prepared**	**Feel Afterwards**
Breakfast:				
Time You Ate the Meal __________	Ex. Oatmeal, nuts, bread	Ex. ½ cup, 1 Tbsp nuts, etc.	Ex. Cooked with salt raw nuts and toast.	Ex. Felt queasy from nuts
Lunch:				
Time You Ate the Meal __________				
Dinner:				
Time You Ate the Meal __________				

FOOD INTAKE: PLEASE INDICATE THE FREQUENCY THAT YOU EAT THE FOLLOWING:

How often do you eat the items below:	Never	2-3 times/mo.	1 time/week	2-3 times/week	1 times/day	2-3 time/day
Fast food, Type:						
Restaurant food						
Vending machine food						
Cafeteria or buffet food						
Frozen meals						
Home-cooked meals						
Leftovers						
Beef (hamburger, steak, etc.)						
Pork (chop, loin, ham, bacon, etc.)						
Liver						
Lamb						
Poultry (chicken, turkey, etc.)						
Deli meat, type:						
Fish, type:						
Soy foods, type:						
Beans, type:						
Crackers, type:						
Cookies, cakes, muffins						
Whole grains, type:						
Fresh/Raw vegetables						
Cooked vegetables						
Fruit, fresh or frozen						
Canned Vegetables or Fruit						
Processed /Boxed Foods, Type:						
Oils & Butter, Type:						
Dairy (Milk, yogurt, cheese). Type:						
Salt, seasoned salts. Type:						
Fried meat/food (chicken, fish), Type:						
Artificial sweeteners/sugar, Type:						
Meal Replacements, Type:						

BEVERAGE INTAKE FREQUENCY:

Please indicate the frequency of the beverages you drink, and how often you drink them. Fill in the "Daily Amount", "Weekly Amount", and/or "Monthly Amount".

Beverage Type:	**Daily Amount**	**Weekly Amount**	**Monthly Amount**
Example: Coffee: X reg decaf latte	**2 – 8 oz cups __**	**3 cups**	**28 x in a month**
Water: ___tap ___filtered ___bottled ____			
Coffee: reg. decaf. latte			
Tea: what type(s)?_________________			
Juice: Natural Fruit drinks			
Soda: regular diet			
Milk: whole 2% 1% skim			
Milk alternative Type______________			
Alcohol: wine beer liquor			
Other Beverage Type: ___________________________			

Thank you for taking the time to complete this questionnaire.