Initial Visit Intake Form

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The People's Wellness Center
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Eugene, OR

Name _____ Date _____

Address _____ City _____ Zip _____ Phone _____

Age _____ Birth Date __/__/__ Referred by _____

Name Of Regular Doctor _____ How Long _____ Date of Last Complete Medical Exam __/__/__

What are your primary health concerns at this time:

Current Symptoms	Date of Onset	Circle One
_____	__/__/__	Gradual / abrupt
_____	__/__/__	Gradual / abrupt
_____	__/__/__	Gradual / abrupt
_____	__/__/__	Gradual / abrupt

Describe how your present condition affects you in relation to your:

Work _____

Family _____

Friends _____

Social Lifestyle:

Marital Status:
? Single ? Married (#of times) ___ ? Separated ? Divorced ? Partnered ? Widowed

Spouse's Name and Age _____

Spouse's Education _____ Spouse's Occupation _____

What do you share in common? _____

_____

Children (Name, Age, Health) _____

_____

_____

Occupation _____ How Long There? _____ Education _____

Do you like your work? _____ Why? _____

Religion _____ Are you actively practicing? Yes / No

Organizations _____

Social Activities / Hobbies _____

How healthy and happy do you expect you should be? (Rate from 0 - 100%) _____

How healthy and happy are you now? (Rate from 0 - 100%) _____

What do you consider to be your most positive attribute? _____

Constitutional Intake Form

Name: Date:

UPPER GI
__ Sometimes nausea in mornings
__ Sometimes nausea in evenings
__ Sometimes excess salivation
__ Mouth frequently too dry
__ Duodenal ulcer
__ Stomach ulcer
__ Sometimes foul burps
__ Butterflies in stomach
__ Seldom eat breakfast
__ Often don't finish meals
__ Often eat to calm down
__ Receding gums
__ Frequent use of alcohol
__ Frequent poor appetite
__ Strong, demanding hunger
__ Bitter taste in morning
__ "Dragon breath" in morning
__ Acid indigestion at night
__ Frequent mouth or cold sores
__ Sometimes difficulty in swallowing
__ Indigestion after eating

LOWER GI
__ Stools loose with gas
__ Constipation with gas
__ Frequent constipation
__ Digestion unusually rapid
__ Loose stools when tired/stressed
__ Light colored, hard stools
__ Dark, soft stools
__ Quick defecation after eating
__ Intestines often bloated
__ Constipation with hemorrhoids
__ " w/ painful defecation
__ " w/ hard, marbly stools
__ " w/ fully formed stools
__ " " alternate w/ diarrhea
__ Frequent need for laxatives
__ Tongue often coated

LIVER
__ Dry, even scaly skin
__ Moist, sometimes oily skin
__ Hives from food or drugs
__ Hay fever or asthma
__ Craves proteins, fats
__ Craves fruit or sweets
__ Frequent trouble digesting fats
__ Acne on face AND buttocks
__ Seems to have low blood sugar
__ Had hepatitis in past
__ Frequent use of alcohol
__ Work with solvents
__ Psoriasis, eczema, dermatitis
__ Frequent minor illnesses
__ Fever w/sweat when sick
__ Don't sweat when sick

RENAL
__ Standing too quickly makes pulse roar in ears
__ Standing too quickly causes faintness, dizziness
__ Wakes up at night to urinate
__ Frequent flushing or blushing
__ Water retention with change of weather
__ Moderate high blood pressure, craves fats
__ Moderate low blood pressure, craves sweets
__ Frequent thirst
__ Craving for salt
__ Urine always light colored
__ Urine usually darker

LOWER URINARY TRACT
__ Frequent urination, small amounts
__ Infrequent urination, copious
__ Sometimes dribbles urine afterwards
__ Frequent bladder infections
__ Demanding and sudden need to urinate
__ Mucus in urine
__ Benign prostatic hypertrophy (males)
__ Dull ache after urination

REPRODUCTIVE - ALL
__ Sweat freely with strong scent
__ Oily skin, facial acne
__ Dry skin, cold hands and feet

WOMEN
__ Cycle more than 28 days
__ Cycle less than 28 days
__ Water retention before menses, hips, breasts
__ Water retention before menses, feet, hands
__ Craves fats, proteins before menses, usually
__ Craves sweets before menses, usually
__ Sides of breasts tender before menses
__ Miss some periods
__ Menses slow starting with cramps
__ Palpitations before menses
__ Menstruation lengthy, frequent cramps
__ Menstruation short, defined, few cramps
__ Frequent Class II Pap Smears
__ History of PID, cervicitis
__ Miscarriages, problem pregnancy
__ Period early w/altitude change
__ Period late w/altitude change
__ Tried, but couldn't handle birth control pills
__ Frequent Candida type infections.

MEN
__ Frequent cannabis user
__ Pain or ache after orgasm
__ Benign prostatic hypertrophy
__ Difficult maintaining erection even if you feel in the mood

Form developed by Michael Moore

Constitutional Intake Form

RESPIRATORY

__ Shortness of breath when standing or walking
__ Tobacco smoker
__ Easy coughing of mucus
__ Difficulty swallowing mucus
__ Rapid, shallow breather
__ Sometimes wake up choking or gasping for breath
__ Yawns frequently
__ Sometimes hyperventilates
__ Frequent chest colds

CARDIOVASCULAR

__ Slow, strong pulse
__ Fast, light pulse
__ Frequent physical activity
__ Warm bodied
__ Cold bodied
__ Sometimes dizzy or faint
__ Hands warm, sweaty
__ Hands cold, clammy or dry
__ Palpitations either as an adolescent or before menses
__ Hypertension, responds to diuretics
__ Hypertension, not responding to diuretic

LYMPHATIC

__ Recuperates quickly if ill
__ Recuperates slowly if ill
__ Injuries heal quickly
__ Injuries heal slowly
__ Eczema, dermatitis
__ Asthma or hay fever
__ Arthritis or rheumatism
__ Digests fats easily
__ Digests fats poorly

SKIN

__ Skin eruptions superficial, come to a head
__ Skin eruptions deep, not coming to a head
__ Skin on trunk is dry
__ Oily scalp or hair
__ Dry scalp or hair
__ Cracks, fissures on heel, feet, slow healing

MUCUS

__Sores, cracks, on mouth, anus, vagina
__Lips often dry, chapped
__Food often causes intestinal pain passing through
__Gets sore throat easily

GENERAL

Mark conditions that are frequent. If it is mild, mark "1"; if it is a dominant condition, Mark "2"

__Aluminum cooking vessels
__Awakens, can't go back to sleep
__Bad dreams
__Blurred vision
__Brown spots, bronzing of skin
__Bruises easily
__Can't gain weight
__Can't lose weight
__Can't get started without coffee
__Chemical or spray poisoning
__Chronic fatigue, depression
__Cry easily without seeming cause
__Depressed for long periods
__Earaches
__Eat often or else faint/nervous
__Eyes often red, inflamed
__Face, eyes get puffy
__Facial twitches
__Gum problems
__Headaches
__Headaches in morning, wearing off
__Heart palpitations when hungry .
__Heart palpitations after eating
__Highly emotional
__Highly controlled
__Impaired hearing
__Increase in weight (recent)
__Lack of sensation somewhere in the body
__Likes depressants
__Likes stimulants
__Lower back pain
__Frequent muscle cramps
__Nails split, brittle
__Nails weak, ridges
__Nose bleeds frequently
__Pollution heavy in work or home environment
__Ringing in ears
__Pulse speeds up after meals
__Sensitive to cold weather
__Sensitive to hot weather
__Sensitive to high humidity
__Sensitive to low humidity
__Sexual desire decreased
__Sexual desire increased
__Stuffy nose during the day
__Stuffy nose in evening, night
__Tendency, seemingly, to anemia
__Tremors in hands or neck
__Varicose veins
__Weight gain in upper arms, shoulders, back of neck

Form developed by Michael Moore

Self Evaluation Form

Name _____ Date _____

Circle a number for each item according to your condition this week. Ask yourself: "How much improvement do I need in order to be healthy and happy?"

Job (answer even if unemployed)	0	1	2	3	4	Answer Key:
Living quarters	0	1	2	3	4	0 = I need no improvement
Spouse or lover (even if you have none)	0	1	2	3	4	1 = I need little improvement
Family	0	1	2	3	4	2 = I need moderate improvement
Friends	0	1	2	3	4	3 = I need much improvement
Social life	0	1	2	3	4	4 = I need very much improvement
Hobbies	0	1	2	3	4	
Sex life (even if abstinent)	0	1	2	3	4	
Religion, philosophy, or meaning of life	0	1	2	3	4	
Ambition	0	1	2	3	4	
Money	0	1	2	3	4	
Self-confidence	0	1	2	3	4	A _____
General Health	0	1	2	3	4	
Physical Energy	0	1	2	3	4	
Resistance to infection or ability to heal	0	1	2	3	4	
Sleep	0	1	2	3	4	
Appetite, digestion, or bowel function	0	1	2	3	4	
Skin, lips, gums, or tongue	0	1	2	3	4	
Breathing, cough, heart, or blood pressure	0	1	2	3	4	
Joints, spine, aches, pains, or headache	0	1	2	3	4	
Allergy, hayfever, asthma, or eczema	0	1	2	3	4	
Sex function or menstrual function	0	1	2	3	4	
Mental concentration ability	0	1	2	3	4	
Memory for recent events	0	1	2	3	4	B _____ AB_____
Anxiety or nervousness	0	1	2	3	4	
Muscle tension or restlessness	0	1	2	3	4	
Indecision	0	1	2	3	4	
Worry	0	1	2	3	4	
Fear or panic	0	1	2	3	4	
Anger or temper outbursts	0	1	2	3	4	
Guilt or shame	0	1	2	3	4	
Resentment or hostility	0	1	2	3	4	
Jealousy or envy	0	1	2	3	4	
Loneliness	0	1	2	3	4	
Withdrawal from people or seclusiveness	0	1	2	3	4	
Boredom, or meaningless, or not caring	0	1	2	3	4	
Depressed mood or low spirits	0	1	2	3	4	
Over-elated mood, too excited or high	0	1	2	3	4	
Impulsive behavior or doing before thinking	0	1	2	3	4	
Daydreaming	0	1	2	3	4	
Putting things off or avoiding goals	0	1	2	3	4	
Irritable, jumpy, or easily startled	0	1	2	3	4	
Medication dependency	0	1	2	3	4	
Alcohol, tobacco, marijuana, or narcotics (underline)	0	1	2	3	4	C _____
Mental confusion	0	1	2	3	4	
Mind dulled, slow, or blank	0	1	2	3	4	
Thoughts racing or repeating	0	1	2	3	4	
Thoughts too loud	0	1	2	3	4	
Feeling unreal or strange	0	1	2	3	4	
Feeling inferior	0	1	2	3	4	
Feeling mistrustful or suspicious	0	1	2	3	4	
Feelings deadened, no feelings	0	1	2	3	4	
Feeling hopelessness about self or life	0	1	2	3	4	
Hearing voices, seeing visions, or hallucinations	0	1	2	3	4	CD _____
Suicidal ideas or self-destructive urges	0	1	2	3	4	Total _____
Homicidal ideas or destructive urges	0	1	2	3	4	D _____

How healthy and happy do you expect you should be? (Rated on a scale of 0 - 100%) _____%
How healthy and happy are you now? (Rated on a scale of 0 - 100%) _____%

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Form developed by Dr. Richard Noble

Name:

Date:

Metabolic Screening Questionnaire

Rate each of the following symptoms based upon your typical health profile for:

❑ Initial test: the past 90 days ❑ Retest: the past 14 days ❑ Retest: the past 48 hours

Grading of Symptoms

0 **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**

Head

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia Total _____

Eyes

___ Swollen, reddened, or sticky eyelids
___ Blurred or tunnel vision (does not include near or far sightedness)
___ Bags or dark circles under eyes
___ Watery or itchy eyes Total _____

Ears

___ Itchy ears
___ Ear aches, ear infections
___ Ringing in ears, hearing loss
___ Drainage from ear Total _____

Nose

___ Stuffy nose
___ Sinus problems
___ Sneezing attacks
___ Excessive mucus formation
___ Hay fever Total _____

Mouth, Throat

___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen or discolored tongue, gums, lips
___ Chronic coughing
___ Canker sores Total ____

Skin

___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Flushing or hot flashes
___ Excessive sweating Total _____

Heart

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain Total _____

Lungs

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficulty breathing Total _____

Digestive Tract

___ Nausea or vomiting
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal or stomach pain
___ Diarrhea Total _____

Joints, Muscles

___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
___ Pain or aches in joints
___ Arthritis Total _____

Weight

___ Binge eating, drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight Total _____

Energy, Activity

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness Total _____

Mind

___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical co-ordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities Total _____

Emotions

___ Mood swings
___ Anxiety, fear, or nervousness
___ Anger, irritability, or aggressiveness
___ Depression Total _____

Other

___ Frequent or urgent urination
___ Genital itch or discharge
___ Frequent illness Total _____

Grand Total _____

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Medical Symptoms Review

Name: **Date:**

Directions: Check each symptom that applies at all in the past month. Circle if important now.

Allergy:
- ❑ Foods
- ❑ Inhalants
- ❑ Additives
- ❑ Hydrocarbons
- ❑ Medicines
- ❑ Aspirin
- ❑ Asthma
- ❑ Eczema

Energy:
- ❑ High
- ❑ Low
- ❑ Normal

Appetite:
- ❑ High
- ❑ Low
- ❑ Normal

Weight:
- ❑ Increased
- ❑ Decreased
- ❑ Unchanged

Headache:
- ❑ Dull
- ❑ Sharp
- ❑ Stabbing
- ❑ Pressure
- ❑ Band around head
- ❑ One side

Frequency:
_____ per month

Duration:
_____ hours

Location:
- ❑ Neck
- ❑ Temples
- ❑ Forehead
- ❑ Eyes
- ❑ Back of head
- ❑ Jaw
- ❑ All over head

Muscles and Bones:
- ❑ Leg cramps
- ❑ Stiff neck
- ❑ Neck pain
- ❑ Whiplash
- ❑ Wry-neck
- ❑ Sore, aching muscles
- ❑ Low back pain
- ❑ Flat feet
- ❑ Painful heels
- ❑ Loss of muscle power
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Arthritis
- ❑ Loss of muscle substance
- ❑ Tired feet
- ❑ Tired climbing stairs
- ❑ Curvature of spine

Skin:
- ❑ Heal slowly
- ❑ Bruise easily
- ❑ Dry
- ❑ Oily
- ❑ Red around nose
- ❑ Acne
- ❑ Boils
- ❑ Scaly
- ❑ Dandruff
- ❑ Itchy
- ❑ Red spots
- ❑ Brown spots
- ❑ Varicose veins
- ❑ Scalp hair loss
- ❑ Body hair loss
- ❑ Seborrhea
- ❑ Psoriasis
- ❑ Brittle nails
- ❑ Brittle hair
- ❑ Eczema
- ❑ Excess hair growth

Hands usually:
- ❑ Warm
- ❑ Cold
- ❑ Wet
- ❑ Dry

Eyes:
- ❑ Near-sighted
- ❑ Far-sighted
- ❑ Astigmatic
- ❑ Colorblind
- ❑ Painful eyeballs
- ❑ Halo around light
- ❑ Poor night vision
- ❑ Glare sensitive
- ❑ Inflamed lids
- ❑ Sandy feeling in eyes
- ❑ Bloodshot
- ❑ See double

Ears:
- ❑ Loss of hearing
- ❑ Hearing too sensitive
- ❑ Earache
- ❑ Motion sickness
- ❑ Dizzy
- ❑ Noises in ears

Nose-throat:
- ❑ Sinus trouble
- ❑ Post-nasal drip
- ❑ Hay-fever
- ❑ Nosebleed
- ❑ Loss of smell
- ❑ Strange odors
- ❑ Loss of taste
- ❑ Metallic taste
- ❑ Bad breath
- ❑ Sore throat
- ❑ Canker sores
- ❑ Change in voice
- ❑ Hoarseness
- ❑ Lump in throat
- ❑ Difficulty swallowing
- ❑ Grinding teeth in sleep
- ❑ Biting tongue
- ❑ Tongue-thrusting

Teeth:
- ❑ Toothaches
- ❑ Tender to cold
- ❑ Cavity-prone
- ❑ Soft
- ❑ Loose
- ❑ Dentures

_____ # extractions

Lips:
- ❑ Dry
- ❑ Chapped
- ❑ Peeling
- ❑ Split
- ❑ Sores at corners

Gums:
- ❑ Bleeding
- ❑ Infected
- ❑ Receding
- ❑ Sore

Tongue:
- ❑ Dry
- ❑ Sore
- ❑ Swollen
- ❑ Inflamed
- ❑ Split
- ❑ Loss of taste

Coated:
- ❑ White
- ❑ Yellow
- ❑ Brown
- ❑ Black

Digestive:
- ❑ Nausea
- ❑ Vomiting
- ❑ Belching
- ❑ Acidity
- ❑ Hepatitis
- ❑ Ulcer
- ❑ Cramps
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas
- ❑ Thin stools
- ❑ Mucus stools
- ❑ Black stools
- ❑ Gray stools
- ❑ Bloody stools
- ❑ Foul-smelling stools
- ❑ Frothy stools
- ❑ Rectal spasm
- ❑ Hemorrhoids
- ❑ Itching anus

Medical Symptoms Review

Digestive (con't):
Laxatives:
_____ # per month

Enema:
_____ # per month

Food intolerance:
- ❑ Wheat
- ❑ Milk
- ❑ Egg
- ❑ Citrus
- ❑ Fried foods
- ❑ Fats
- ❑ Yeast

Bowel movements usually
_____ # per week

Chest:
- ❑ Cough
- ❑ Night sweats
- ❑ Painful breathing
- ❑ Asthma
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Short of breath
- ❑ Green
- ❑ Yellow or bloody sputum
- ❑ Pleurisy
- ❑ Chest pain on exertion
- ❑ Irregular pulse
- ❑ Rapid pulse
- ❑ Palpitation
- ❑ Fainting
- ❑ Blackout if get up quickly
- ❑ Heart murmur
- ❑ High blood pressure

Genitourinary:
- ❑ Burning urination
- ❑ Loss of control of urination

Frequency:
_____ # per day
_____ #per night

- ❑ Urgency
- ❑ Difficulty starting
- ❑ Pain in flank
- ❑ Kidney stones

Discolored urine:
- ❑ Black
- ❑ Brown
- ❑ Bloody

- ❑ Hernia
- ❑ VD
- ❑ Lack of sexual information or experience
- ❑ Loss of sex drive
- ❑ Increase in sex drive

Women only:
Menstrual period
_____days
Cycle _____ days
Pregnancies _____
Miscarriages _____
Abortions _____

- ❑ Menstrual cramps
- ❑ Irregular periods
- ❑ Nervous before periods

Flow:
- ❑ Heavy
- ❑ Medium
- ❑ Light

- ❑ Lack of sexual secretions
- ❑ Lack of orgasm
- ❑ Vaginal discharge

Date of last pap smear _____

Men only:
- ❑ Loss of erections
- ❑ Premature ejaculation
- ❑ Sore on penis
- ❑ Pain or swelling in groin

Sleep:
Need _____ hours
Get _____ hours

- ❑ Slow to fall off
- ❑ Early waking
- ❑ Restless
- ❑ Disturbing dreams

Spells:
- ❑ Anxiety
- ❑ Heart pounding
- ❑ Rapid breathing
- ❑ Panic
- ❑ Weeping
- ❑ Depression
- ❑ Elation
- ❑ Anger
- ❑ Nausea
- ❑ Irritability
- ❑ Poor concentration
- ❑ Yawning
- ❑ Drowsy
- ❑ Trance
- ❑ Dizziness
- ❑ Misbehavior
- ❑ Memory black-out
- ❑ Loss of consciousness
- ❑ Convulsions
- ❑ Weak
- ❑ Shaky
- ❑ Chills
- ❑ Sweats
- ❑ Hot flashes

Spells occur:
- ❑ Before meals
- ❑ After meals
- ❑ If hungry
- ❑ If upset
- ❑ Morning
- ❑ Afternoon
- ❑ Evening

Nerves:
- ❑ Numbness
- ❑ Tingling
- ❑ Burning
- ❑ Shooting pains
- ❑ Weakness
- ❑ Dropping things
- ❑ Stroke
- ❑ Tics
- ❑ Change in handwriting
- ❑ Change in personality
- ❑ Loss of memory
- ❑ Inability to concentrate
- ❑ Tremor
- ❑ Sudden jerks of body or extremities
- ❑ Twitching in falling asleep
- ❑ Loss of balance
- ❑ Clumsiness

Cravings:
- ❑ Water
- ❑ Sweets
- ❑ Salt
- ❑ Vinegar
- ❑ Citrus
- ❑ Meat
- ❑ Fat
- ❑ Eggs
- ❑ Dairy
- ❑ Alcohol
- ❑ Tobacco
- ❑ Bread

Medicines used in past month:
- ❑ Antibiotic
- ❑ Antacid
- ❑ Antispasmodic
- ❑ Laxative
- ❑ Antihistamine
- ❑ Codeine
- ❑ Muscle relaxant
- ❑ Tranquilizer
- ❑ Sedative
- ❑ Sleeping pill
- ❑ Antidepressant
- ❑ Stimulants
- ❑ Diet pill
- ❑ Water pill
- ❑ Heart pill
- ❑ Thyroid
- ❑ Cortisone
- ❑ Birth control pill
- ❑ Female hormone
- ❑ Male hormone
- ❑ Asthma medication
- ❑ Inhaler
- ❑ Nasal decongestant
- ❑ Pain pill
- ❑ Anticonvulsant
- ❑ Aspirin
- ❑ Chelation therapy
- ❑ HCG injection
- ❑ B12 injection
- ❑ Vitamin
- ❑ Mineral
- ❑ Other_____

_____
_____
_____
_____
_____
_____
_____
_____

Medical History

Check any diseases, which you or your relatives have had.

Relatives	arthritis	asthma	cancer	diabetes	substance abuse	gout	heart disease and/ or stroke	high blood pressure	hypo-thyroidism	kidney disease	neurological disease	periodontal disease	Athero-schlerosis	obesity
You														
Father														
Mother														
Brothers														
Sisters														
Spouse														
Children														
Maternal grandparents														
Paternal grandparents														

Circle any other illnesses that you now have or have had in the past:

Acne
Aids
Allergies
Anemia
Anorexia
Back problems
Benign breast tumor
Bronchitis
Bulimia
Candida Albicans
Cataracts
Chicken pox
Cirrhosis
Crohn's disease
Depression
Diverticulosis
Ear infections
Eczema
Endometriosis
Excessive fatigue
Eye disease
Gallstones
Gastritis
Gingivitis
Goiter
Gonorrhea
Hay fever
Hemorrhoids
Hepatitis
Hernia
Herniated disc
Herpes
Hives
Kidney stones
Low-blood pressure
Lupus
Malaria
Measles
Mononucleosis
Multiple sclerosis
Mumps
Nervous breakdown
Pancreatitis
Pneumonia
Polio
Psoriasis
Rheumatic fever
Rheumatoid arthritis
Scarlet fever
Sciatica
Syphilis
Other _____

Type of Major Surgery	Date	Physician

Circle any of the following medications you are taking:

Antacids
Antibiotic/antifungal
Antidepressants
Anti-diabetic/insulin
Aspirin/Tylenol
Chemotherapy
Cortisone/anti-inflammatories
Cold medication
Cough medicine
Diet pills
Heart medications
High blood pressure
Hormones
Laxatives
Lithium
Oral contraceptives
Radiation
Recreational drugs
Relaxants
Sleeping pills
Thyroid
Ulcer medications
Other _____
_____

For anything circled, list:

Name	Dosage	How long you have been taking it?

Diet Survey

Name _____ Date _____

Fill in mealtime and typical menu in your diet in the past week:

Breakfast	____ o'clock	_____
Snack	____ o'clock	_____
Lunch	____ o'clock	_____
Snack	____ o'clock	_____
Dinner	____ o'clock	_____
Snack	____ o'clock	_____

Specify Food Frequency (x) or amount (#) as indicated below:

Eggs ____ per week

Milk ____ quarts per week

- ❑ Whole
- ❑ Skim
- ❑ Low fat
- ❑ Buttermilk
- ❑ Kefir
- ❑ Powdered
- ❑ Half and Half

Cheese ____ ounces per week

Cottage Cheese ____ pints per week

Yogurt ____ pints per week

Ice Cream ____ pints per week

Liver ____ x per week

Fish ____ x per week

Shellfish ____ x per week

Fowl ____ x per week

Yeast ____ tbsp. per week

Beef ____ x per week

Lamb ____ x per week

Bacon ____ x per week

Ham or Pork ____ x per week

Sausage ____ x per week

Hamburger ____ x per week

Hot-dog ____ # per week

French Fries, Chips ____ x per week

Soybean or Tofu ____ x per week

Nuts ____ ounces per week

Types of Nuts: _____

Types of Nuts: _____

Seeds ____ ounces per week

Types of Seeds: _____

Types of Seeds: _____

Peanut Butter ____ x per week

Other Nut Butter ____ x per week

Type of Nut Butter: _____

Butter/Margarine ____ # pats per day

Salad Oil ____ # tbs. per day

Mayonnaise ____ x per week

Sour Cream ____ x per week

Bread ____ slices per day

- ❑ White
- ❑ Whole Wheat
- ❑ Crackers

Cereal ____ x per week

Specify Type _____

Spaghetti/Pasta ____ x per week

Soup ____ x per week

Salad ____ x per week

Vinegar ____ x per week

Cooked Vegetables ____ x per week

Method:

- ❑ Steamed
- ❑ Boiled
- ❑ Sauté
- ❑ Baked

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Underline those eaten at least once in the past two weeks

Vegetables ____ total servings per week

Artichoke	Asparagus	Bamboo Shoots	Barley	Bean Sprouts
Beet Greens	Beets	Broccoli	Brussel Sprouts	Cabbage
Carrots	Cauliflower	Celery	Chard	Chervil
Chicory	Chinese Cabbage	Chives	Collard Greens	Corn
Cucumbers	Dandelion Greens	Eggplant	Endive	Fennel
Green Beans	Green Onions	Green Peppers	Hominy	Kale
Kohlrabi	Leeks	Legumes	Lentils	Lettuce
Mushrooms	Mustard Greens	Okra	Olives	Parsnip
Peas	Parsley	Pickles	Pimientos	Potatoes
Pumpkin	Radishes	Red Peppers	Rhubarb	Rice
Rutabaga	Soy bean	Sour Kraut	Spinach	Summer Squash
Sweet Potatoes	Tomato	Turnip	Turnip Greens	Water Chestnut
Watercress	Winter Squash	Yams	Zucchini	

Underline those eaten at least once in the past two weeks

Fruits ____ total servings per week

Apples	Casaba melon	Gooseberries	Lime	Pineapple
Apricots	Cherries	Grapes	Loganberries	Plums
Avocado	Coconut	Grapefruit	Mangoes	Raspberries
Banana	Cranberries	Guava	Muskmelon	Strawberries
Blackberries	Dewberries	Honeydew	Oranges	Tangerines
Blueberries	Dried Fruit	Melon	Papaya	
Boysenberries	Elderberries	Huckleberries	Peaches	
Cantaloupe	Fruit Salad	Lemon	Pears	

Juices ____ # glasses per day

Specify:

- ❑ Apple
- ❑ Apricot
- ❑ Carrot
- ❑ Celery
- ❑ Grape
- ❑ Grapefruit
- ❑ Lemon
- ❑ Orange
- ❑ Pineapple
- ❑ Prune
- ❑ Tomato
- ❑ V8

Coffee ____ # cups per day

Decaf ____ # cups per day

Tea ____ # cups per day

Water ____ # glasses per day

Soft Drinks ____ # glasses per week

- ❑ Cola
- ❑ Lo-cal
- ❑ Regular

Tobacco ____ # per day

- ❑ Pipe
- ❑ Cigar
- ❑ Cigarette

Wine ____ # oz. per day ____ days a week

Beer ____ # oz per day ____ days a week

Liquor ____ # oz per day ____ days a week

List all you vitamins and food supplements on reverse side.

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Nutritional History

Name _____ Date _____

Food Type	Age 0-2	Age 2-5	Age 5-13	Age 13-21	Adult	Past Year
Meat						
Fish						
Milk						
Cheese						
Eggs						
Whole Grains						
Seeds, Nuts						
Fresh Fruits						
Fresh Vegetables						
Vitamin Supplements						
Sweets, Soft Drinks						
Alcohol						
Tobacco						
Illness Symptoms						

Key

0 = none
(0 - 2 x per month)

1 = occasionally
(2 - 4 x per month)

2 = frequently
(2 - 4 x per week)

3 = daily
(5 x per week or more)

List any vitamins, minerals, self-care materials, herbal remedies, or food supplements you are currently taking.

Item	Dosage	How Long Used

Check if you eat, drink, or use:

- ❑ Alcohol
- ❑ Candy
- ❑ Carbonated Beverages
- ❑ Cigarettes
- ❑ Coffee
- ❑ Distilled Water
- ❑ At Fast Food Restaurants Regularly
- ❑ Fried Foods
- ❑ Luncheon Meats
- ❑ Margarine
- ❑ Refined Sugars
- ❑ Saccharine, Sweet and Low, Equal
- ❑ Nutra-Sweet

Check if you:

- ❑ Diet often
- ❑ Do not exercise regularly
- ❑ Salt food without tasting
- ❑ Are under excessive stress
- ❑ Are exposed to chemicals at work
- ❑ Are exposed to cigarette smoke

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