



Confidential Nutritional Health History

Today's Date _____

Name _____ Birth Date _____ Age ____ Height ____' ____" Weight ____ lbs

Address _____ City _____ State ____ Zip _____

Phone: _____ Cell: _____ Email: _____

May we thank who referred you? _____

Who is your primary physician? _____

Who is your dentist? _____

Other provider? _____

**** Please answer all questions carefully. They are the clues to you. ****

HEALTH HISTORY

List your Primary Concerns/Reasons for this consult:

When did it begin?

Rate each

_____	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe
_____	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe
_____	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe
_____	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe

What has been done so far? (self-treatment, or professional treatment?)

Did it help?

List any secondary health concerns, or problems you are having:

What is your daily Stress Level ? circle one (0 1 2 3 4 5 6 7 8 9 10 extreme)

What is your daily Energy Level ? circle one (0 1 2 3 4 5 6 7 8 9 10 extreme)

How many Hours at Work/School? # _____ hrs/wk ,

Do you get Adequate Sleep? Yes, how much? _____ hrs No, why? _____

Do you feel well rested when you wake up in the morning? Yes No

What time to you normally go to bed? _____ pm am

Rate the quality of your sleep (1 being awful & 10 being great): (_____)

What are your Goals for this Nutritional Evaluation? _____

What are your Barriers to Success, if any? (e.g. time, motivation, etc.) _____

Have you had any LOSS in your HEIGHT? No Yes, how much? _____”

Have you had any CHANGES in WEIGHT in the past year? No Yes, # ___ lbs Gain Loss

What is; your Usual Weight? _____ Lbs, what is your Ideal Weight? _____ Lbs,

the Most you have Weighed? _____ Lbs, at What age? _____ years old.

your Lowest (Adult) Weight? _____ Lbs, at What age? _____ years old.

Have you had any recent LAB Tests done? No/ Yes, [basic blood & urine], Lipid/metabolic panel, Thyroid, Salivary hormone tests, Blood Hormone test, Hair analysis for heavy metal & mineral survey, GI digestive health stool analysis, MicroNutrient survey, Food/Air allergy/sensitivity testing. Iodine spot urine test

Other _____

****PLEASE GET COPIES OF ALL RECENT LABS TO DR. ROSS. IF NONE, CALL THE OFFICE FOR DETAILS OF WHAT IS NEEDED****

LIST ALL PRESCRIPTION DRUGS TAKEN:

CURRENT (less than a year)

Why? / What diagnosis?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST (more than a year)

Why? / What diagnosis?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALL NON-PRESCRIPTION OTC DRUGS - CURRENT

Reason?

How long taken? Dose?

_____	_____	_____
_____	_____	_____
_____	_____	_____

ALL VITAMINS, SUPPLEMENTS, HERBS - CURRENT

Reason?

How long taken? Dose?

Surgery?

When?

Why?

Result?

Any Known Allergies or Sensitivities to Foods or Environmental Agents?

Describe your Reaction(s)

Do you react to? Gluten (wheat, rye, barley) Lactose Eggs Other_____ None Don't know

Do you smoke? No Yes, #___years? #___ cigarettes packs per day Quit, What year?_____ #___years smoked?

If Yes, Are You Ready to Quit? Yes No, reason_____

Do you use? Snuff, Chew, Cigars, Marijuana (light moderate heavy)

Do You Currently Exercise? No Yes, what do you do? _____

___ times per week for (15 20 30 45 90 minutes or more) per exercise session

If No, what exercise would you consider? Fast Walking Exercise Class Personal trainer Yoga Exercise video's
other_____

Do you have any limitations on exercise? No Yes, explain_____

My mother was Healthy when pregnant with me. Don't know Yes No, (explain)

I was delivered by: natural birth C-section with forceps mother had anesthesia premature don't know

Were you breastfed at least 6 months? Don't know yes no

Were you a colicky baby? Don't know No yes, until what age?_____

Which foreign countries have you been to, or lived in? _____

Have you ever fainted, or had convulsions? (explain)

DIETARY HISTORY – (Please Be Brutally Honest Here - The More Real Your Answers the More Help You Will Receive)

Would it be difficult for you if a change in your current eating habits are recommended,? No Yes, explain?

Your Liquid Consumption: (0 for None)

Water:	#__ 12oz glasses a <input type="checkbox"/> day <input type="checkbox"/> week	Milk:	#__ 12oz glasses a <input type="checkbox"/> day <input type="checkbox"/> week
Coffee:	#__ 6 oz glasses a <input type="checkbox"/> day <input type="checkbox"/> week	Beer:	#__ 12oz glasses a <input type="checkbox"/> day <input type="checkbox"/> week
Tea:	#__ 6 oz glasses a <input type="checkbox"/> day <input type="checkbox"/> week	Wine:	#__ 12oz glasses a <input type="checkbox"/> day <input type="checkbox"/> week
Soda:	#__ 12oz glasses a <input type="checkbox"/> day <input type="checkbox"/> week	Liquor:	#__ 6 oz glasses a <input type="checkbox"/> day <input type="checkbox"/> week
Diet Soda:	#__ 12oz glasses a <input type="checkbox"/> day <input type="checkbox"/> week		
Energy drinks:	#__ 46oz glasses a <input type="checkbox"/> day <input type="checkbox"/> week	_____:	#__ 12oz glasses a <input type="checkbox"/> day <input type="checkbox"/> week

Alcoholic No, Yes, How long?_____years

Diet Preference: Vegetarian, Vegan, Mostly Vegi / Some Meat Mostly Meat / Some Vegi Fish Chicken Beef Soy Other

In your opinion, is your current diet mostly healthy? Yes No, explain?

My appetite is: normal excessive Sporadic poor no appetite. **I Eat:** fast medium slow Other

List Your 10 Favorite Foods Eaten Most Frequently?

- | | |
|---------|----------|
| 1 _____ | 6 _____ |
| 2 _____ | 7 _____ |
| 3 _____ | 8 _____ |
| 4 _____ | 9 _____ |
| 5 _____ | 10 _____ |

List Your Least Favorite Foods?

Any Food Cravings? No Yes, What are they?

How Many Meals Do You Normally Eat on Work Days? #__ meals a day. **On Weekends?** #__ meals a day.

What % of your meals are: Fresh Home __%, Packaged/Frozen __%, Restaurant __%, Fast Food __%, Vending Machine __%

What % of your meals are: baked __%, broiled __%, boiled __%, fried __%, charcoal __%, steamed __%, raw __%,

Rank in Order of Preference: (1 2 3 4 5 Etc) Sweet __, Sour __, Salt __, Chocolate, Water __, Dirt __, Other _____

Do You Snack? No Yes, What Do You Normally Snack On? _____

How many times a week do you eat the following? None

ice cream/frozen desserts #__ per week, cookies #__ per week, sweet roll/pastries #__ per week,
candy, candy bars #__ per week, desserts pie, cake #__ per week, other sweets _____ #__ per week

Do You Eat Before Bedtime? No Yes, What? _____

Are you on a Special Diet? No, Low Sodium, Low Fat, Atkins, South Beach, other _____

Have You Ever Done Any Forms Of Detoxification? Explain

Do you regularly eat Fermented Foods? No Yes, which ones; Sauerkraut, Keefer , Yogurt (lowfat, flavored, plain),
miso, Natto, other) _____

Do you try to eat Low Fat &/or No Fat Foods? No Yes, what? _____

DIGESTION & ELIMINATION

Do you have any digestive upset after eating? No/Yes, Stomach Ache Nausea Constipation Diarrhea Gurgling
Flatulence/foul odor Flatulence/mild odor other

What foods disagree with you? None Raw Vegetables Raw Fruit Fats Milk/Dairy Greasy Beans Cabbage Eggs
Sugar Onions Highly Spiced Other

I get pain/heartburn: before eating after eating when lying down upon arising

Have: Frequent Heartburn Hiatal Hernia, Esophageal Burning/Reflux, Must Raise Head In Bed To Sleep, Anorexia,
Bulimia, IBS (Irritable Bowel Syndrome), Ulcers, Ulcerative Colitis, Crohn's Disease, Diverticulitis

How often do you have bowel movements? #____ times a day, or #____ times a week.

Average Stool - Size/Shape: 2"x6", 1'x4" Thin Short long, other) _____

- Consistency: Constipation, Hard, ClayLike Sticky, Soft, Easy, Loose Watery Diarrhea
Other)

- Stool Color: Med/Dark Brown Dark Brown/Black Yellow/Tan/Clay Greenish Blood Visible Mucus

Do you use laxatives? No yes how often? daily, #__ a week, #__ a month, #__ a year..

Do you have Pain with Bowel Movements? No Yes, (Mild Moderate severe).

Do you have, or get hemorrhoids? No Yes, (Mild Moderate severe). Do they bleed? No Yes, (Rarely, Often)

Have you ever had worms or parasites? No Yes, how are they treated? _____

Do You Get Rectal Itching? No Yes, how often? _____

I urinate: #____ x per day, #____ X at Night, More Frequently than Normal, With Pain, With Difficulty Starting or Stopping,
with Itching, with Burning Other

My urine color is: Clear, Pale Yellow, Bright Yellow, Dark Yellow, Cloudy, Mucus, Blood, It Varies
Other

HEAD, MOUTH, THROAT

Teeth: Good, Ok, Not So Good, Some Fillings, Root Canals , Some Missing, All Missing,
Dentures, Upper, Lower, Partials, Crowns, More Than One Metal Type In Mouth.

Breath: Good, Slight Odor, Odor Off And On, Usually Offensive Odor.

Tongue: Pink, Red, Blotchy, Pink/ Red Tip, Sore, Furrowed, Coated _____

Tonsils: Normal, Removed at _____ years old, Enlarged, Spotted, Other _____

Eyes: Glaucoma, Cataracts, Other _____

My Sense Of Taste Is: Normal, Poor, No Taste, Over Salted Food, Canker Sores.

My Lips Are: Normal, Dry, Feel A Lot, Fever Blisters Often, Cracks in the Corners.

I Get Headaches: Never, Rarely, Daily, Weekly

Usually: First Thing In The Morning, In The Afternoon, At Night, Other

MUSCLE, LIGAMENT, JOINT, NERVES, BLOOD VESSELS

I often get pain in the: neck, under the shoulder blade, mid back, low back, hip, knee, ankle, feet, sciatica/leg, shoulder, elbow, wrist, hands, other

I get: swollen joints, sore joints, joints that popular crack, job pops, legs cramp at rest, legs cramp with activity, foot cramps at rest, worse at night, foot cramps with activity, flat feet, burning feet, tingling in feet or hands. Other

I: fall asleep easily, hard time falling asleep, often wake up & can't back to sleep, often wake up 2am to 4am.

Have/had: Osteoarthritis, Rheumatoid Arthritis, Gout, Osteoporosis (mild moderate severe), Pinched Nerve, Herniated Disk, Fibromyalgia/Myofascial Pain Syndrome, Nervous Tic or Twitching, Bell's palsy, Ear Ringing, Spinal Surgery(explain) Vascular Surgery (explain) Anemia, Bleeding Disorders, Varicose Veins, Spider Veins, (Explain)

HAIR, NAILS, SKIN

HAIR: Coarse, Fine, Falls out excessively, Turned grey at age ____, Oily, Dry

MALE BEARD: Heavy, Light or sparse, None,

FEMALE: Facial hair always, Facial hair started at age _____, Hair on abdomen or breasts

FINGER NAILS: Normal, Brittle/break easily, Soft, Ridged vertically, White spots, Ridged horizontally, Grow Fast, Grow Slow, Shaped Oddly, Hangnails Other

SKIN: Normal, Oily, Flaky, Psoriasis, Boils, Small Bumps on Upper Arms, Skin Cancer Removed on _____ (date), Had More Than One Skin Cancer # _____

SPOTS ON SKIN: Warts, Moles, Small Red, Large Red, Brown, White

HANDS & FEET: Dry, cracked or bleeding areas on (Hands, Heels, Feet), Ingrown Toenails, Fungus on Feet or Nails, Athletes Foot Other

CHEST & HEART

Have chest pain: Sharp, Dull, Severe, Radiates to my (arm neck back), Worst at Rest, Worst at Exertion, Better with exercise, No change with exercise, Other

Pulse/Heartbeat: Too fast, Too Slow, Skips Beats, Other

I have been told I Have: High Blood Pressure, Low Blood Pressure, Heart Disease, Atherosclerosis/Clogged Arteries, High Cholesterol, High Triglycerides, High Blood Sugar, High CRP (C-Reactive Protein), High Triglycerides, Low Blood Sugar (Hypoglycemia), I had a Glucose Tolerance Test it was (Positive, Negative), Insulin Resistance, Diabetes, (type 1type 2), Metabolic Syndrome, Syndrome X, Central Obesity, Other

Have/ had: Pacemaker, By-Pass Surgery, Stent, Heart Attack, Stroke, (Explain)

RESPIRATORY

Nasal Congestion: Daily, Several Times a Week, Only on Occasion

Nasal Discharge: Daily, Several Times a Week, Only on Occasion, Other

It is: Clear, Yellow, Green, Blood Tinged, Other

Have: Nonproductive Cough [w/o mucous], Productive Cough [with mucous], Allergies, Hoarseness of Voice,
Postnasal Drip, Hay fever, Asthma, Wheezing, Snoring

Have/have had: Frequent Colds, Flu Once or more a Year, Pneumonia, Sinus Infections,
Allergies to _____, Antibiotics (3 or more times in my Life)

I take: Allergy Shots, Allergy Medicine, Decongestants, Nasal Sprays, Steroids

Been told I have/had: Pneumonia, Emphysema, Asthma, Bronchitis, Tuberculosis (TB), Other Respiratory/Lung disease,
(Explain)

I am/have been exposed to: Toxic Chemicals, Toxic Fumes, Craft Chemicals, Second Hand Smoke
(Explain)

EMOTIONAL, NERVOUS & METABOLIC

I am/have: Nervousness, Anxiety (mild moderate severe), Depression (mild moderate severe),, Sensitivity to Noise,
Ease Confusion, Sleepy During Days, Exhausted a lot, Fatigue Easily, Loss of Appetite, Rage, Fearful,
Hear Voices, Weakness, Poor Memory, Irritability, Morbid Thoughts, Suspicious of Others,
Thoughts of Suicide, Quick Mood Changes, Fear of Insanity, Avoid Crowds, People Avoid Me,
Fear of Serious Disease Like _____ Other

Have: Adrenal Fatigue, Hypothyroid; Hashimoto's, Grave's disease (hyperthyroid), Goiter,

I: Take Daytime Naps, Dream Too Much, Have No Dreams at all, Have Nightmares

I: Insomnia (mild moderate severe), Wake up tired, Am cold when others are comfortable, Feet Too Hot, Have Cold Hands,
Have Cold Feet, Perspire Too Much, Have Too Little Perspiration with Exercise

My libido (sex drive) is: Normal, Excessive, Increased, Diminished, Absent

Please check all that apply (C = Current, P = Past)

C P

- AIDS/HIV
- Herpes
- Chickenpox
- Hepatitis
- Kidney disease
- Limes Disease

C P

- Mononucleosis
- Multiple Sclerosis
- Measles
- German Measles
- Mumps
- Parkinson's disease

C P

- Polio
- Rheumatic Fever
- Rosella
- Scarlet Fever
- Cancer _____
- _____

MEN ONLY:

Have/had: BPH (Benign Prostatic Hypertrophy), ED (Erectile Dysfunction), _____

I am on: Hormone Replacement Therapy (Bio-Identical, Synthetic) what? _____

FEMALE ONLY:

Are you pregnant, or think you could be? No Yes, when are you due? _____ Date of last menstrual period _____

Have a Normal cycle, Regular cycle every ____ days, Irregular cycle, No Period in ____ Months/Years, Painful on First Day,
Cramps, Heavy Flow, Scanty Flow, PMS, Hot Flashes, Sweats, Painful Before & During, 2 or more cycles a Month,
Clots, (Explain)

First Period age? _____, Abnormal Since age _____, Menstrual Problems Before First Child, Menstrual Problems After first Child, Menopause, at what age? _____, Hysterectomy, at what age? _____,

I am on: Hormone Replacement Therapy (Bio-Identical, Synthetic), what? _____

Birth Control Pills, was on Birth Control, but Stopped on _____ (Date),

Menstrual Blood Color is: Pink, Red, Brown, Black, Other _____

Have / Had: PCOS, Endometriosis, Constipation with Periods, Diarrhea with Periods, Uterus is in Position,
Uterus is out of Position, Prolapsed Uterus, Prolapsed Bladder,

Breast soreness: Before Periods, During Periods, After Periods, All Month Long

Breasts: Firm, Soft, Implants, Reduction Surgery(date) _____, Breast Lumps, Fibrocystic Breasts,
Have/Had Breast Cancer (explain)

Have: No Children, # ____ Children, Have Been Pregnant # _____ Times,

I get: Bladder/Urinary Tract Infections (UTI), Candida (Yeast Infections), Yeast Infections After Antibiotics,
Vaginal Burning/Itching (Inside, Outside), Vaginal Dryness, Painful Intercourse

Do you have any other past or present health issues not covered in this questionnaire, or general health concerns that you think the doctor should know about? No Yes, Please explain;

OUR FINANCIAL POLICY

To keep our costs and prices low we operate on a cash basis. We do not bill insurance. On request we will provide you with a statement you can mail to your insurance company for direct reimbursement according to the terms of your contract with them.

Patient/Parent/Guardian **Signature** _____ **Date** _____