NATASHA ASSELSTINE

HOLISTIC NUTRITION

NUTRITIONAL INTAKE FORM

For office use only

Date:______________ Full Name:______________________________

Birthdate: *(MM/DD/YY)*______________ Sex:____ Weight:______ Height:________

Street Address:____

City:__________________ Province:______ Postal Code:______________

Phone: *(H)* ______________ *(W)*______________ *(C)* ______________

Email address:____

Preferred method of contact? (Please circle one) Email / Phone

How did you hear about us?____________________________________

Would you like to be included on Vitalia's e-newsletter distribution list to be kept up-to-date on Vitalia promotions, wellness news and other happenings? *Yes / No*

What are your main health concerns? *Please list in priority.*

____

____

____

What would you like to achieve by coming here today? ______________________

____

Have you experienced any major trauma in the past 5 years? ________________

What level of stress do you feel you are experiencing at this time? *Please quantify on a scale of 1 (low) to 10 (high): 1 2 3 4 5 6 7 8 9 10*

Is this level of stress **low**, **normal** or **high** for you?______________

What are the major causes of stress in your life? *Please quantify* ***all that apply****.*

_____ Financial	_____ Marriage	_____ Spiritual
_____ Career	_____ Health	_____ Unfulfilled expectations
_____ Personal	_____ Family	_____ Other *(please elaborate)* ______________

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How does stress manifest itself? ______

Do you use any coping mechanisms? ______

Please rate your wellness in the following areas: *Quantify **all that apply** on a scale of 1 (low) to 10 (high):*

Sleep ______ Weight ______

Mood ______ Body pain ______

Eating habits ______ Mental wellness ______

Exercise ______ Time management ______

Relationships ______

What do you do for exercise? ______

How frequently do you exercise? ______

What time of day and for how long to you exercise? ______

Please rate your energy levels: *1 (low) to 10 (high)* *1 2 3 4 5 6 7 8 9 10*

Do you experience any lulls or highs in your energy levels throughout the day? ______
If **yes**, at what time of day? ______

How many hours on average do you sleep daily? ______

What time do you go to sleep? ______ Awaken? ______

Do you have trouble falling asleep? *(Please circle one)* *Yes / No* Staying asleep? *Yes / No*

Do you awaken feeling rested? *Yes / No* Do you snore? *Yes / No*

What is your occupation? ______

Do you enjoy your work? *Yes / No* How many hours each day do you work? ______

At what times do you start and end work? ______

Do you work shifts or are on a regular schedule? ______

How many hours do you spend daily, on average:

Driving ______ *Watching television* ______ *Reading* ______ *In front of the computer* ______

What are your interests and hobbies? ______

Do you actively participate in any spiritual discipline *(church, religious groups, mindfulness, meditation, etc.)*? *Yes / No* If **yes**, please describe ______

Do you vacation regularly? *Yes / No* When was your last vacation? ______

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Do you smoke? *Yes / No* If **yes**, how much and since when? ______________________________

If **no**, does anyone in your household or workplace smoke? *Yes / No*

Do you use recreational drugs? *Yes / No* If yes, what type? ______________________________

Have you ever been treated for drug and/or alcohol dependency? *Yes / No*

Do you wish to gain weight? *Yes / No* Lose weight? *Yes / No*
If **yes** to either, how much? ______________

When do you wish to reach your goal weight? ______________________________

What is your main motivation to change your weight? ______________________________

How often do you have a bowel movement? ______________________________

Do you strain to have a bowel movement? *Yes / No / Sometimes*
Related to a particular food or circumstance? ______________________________

Do you have loose bowel movements? *Yes / No / Sometimes*
Related to a particular food or circumstance? ______________________________

Is there undigested food in your stools? *Yes / No / Sometimes*

MEDICAL HISTORY

Are you currently taking any medication? *Yes / No*
If **yes**, list all medications and the reason(s) for each: ______________________________

Have you taken antibiotics in the past 5 years? *Yes / No*
Do you take antacids? *Yes / No / Sometimes*

Please list vitamins, minerals, herbal or homeopathic remedies or any other supplements you are currently taking and the amounts/dosages: ______________________________

Do you have any allergies or sensitivities? *Yes / No* If **yes**, please list: ______________________________

Do you have any anaphylaxis (life-threatening allergy)? *Yes / No* If **yes**, please describe:

Have you ever been:

a) Diagnosed with an illness? *Yes / No* If **yes**, please explain: ______

b) Hospitalized? *Yes / No* If **yes**, for what reason? ______

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Have you had surgery to remove your gall bladder? Tonsils? Appendix? ______

Have you had kidney or gall stones? *Yes / No* Do you have silver-mercury fillings? *Yes / No*

Have you ever experienced fungal infections (ex: jock itch, athlete's foot)? *Yes / No*
If **yes**, please describe: ______

Have you experienced a decline in sexual interest: *Yes / No*
If **yes**, please describe: ______

FEMALES

Do you take birth control? *Yes / No* If **yes**, which type? ______

Are you or could you be pregnant? *Yes / No*

Have you noticed any changes in menses (ex: frequency, duration, flow, etc)? *Yes / No*
If **yes**, please describe: ______

Do you suffer from PMS symptoms? *Yes / No* If **yes**, please describe: ______

______

Are you pre-menopausal? *Yes / No* Post-menopausal? *Yes / No*
Are you experiencing any menopausal symptoms? *Yes / No*
If **yes**, please describe: ______

Have you had a bone density test? *Yes / No* If **yes**, what was the result? ______

MALES

Have you experienced any prostate problems (ex: frequent urination, discomfort during urination)? *Yes / No* If **yes**, please describe: ______

FAMILY HISTORY

Please indicate any hereditary diseases. Use" F" for Father, "M" for Mother, "S" for sibling, "G" for grandparent, "O" for others:

____ Allergies	____ Autoimmune Disease	____ Heart Disease	____ Mental Illness
____ Alcoholism	____ Diabetes	____ Hypertension	____ Osteoporosis
____ Arthritis	____ Drug Abuse	____ Intestinal Disease	____ Skin Conditions
____ Asthma	____ Gall Bladder Issues	____ Kidney Dysfunction	____ Ulcers

____ Cancer – Type: ______

____ Other diseases: *(Please list)* ______

DIETARY HABITS

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How many times a day do you eat: ______________________

Time of main meals: ______________ **Time of snacks:** ______________

Do you eat... *(Check all that apply)*

____ with family? ____ at restaurants? ____ on the run?

____ home alone? ____ fast food?

Do you feel there are restrictions to your diet due to preferences of others such as family, roommates, etc.? *Yes / No* If **yes**, please describe: ______________________

____

Are you a meat eater, vegetarian, vegan, or on a specific diet? ______________

How often do you eat meat? __ Daily __ 3-5 x/week __ Once or less than a week

Dairy products? __ Daily __ 3-5 x/week __ Once or less than a week

How many **1 cup** servings of the following do you typically eat in a day?

Fruit *Fresh:* ____ *Dried:* ____ *Canned:* ____

Vegetables *Raw:* ____ *Cooked:* ____

Whole Grains: ____

Protein: ____ *Type:* ______________

Dairy: ____ *Type:* ______________

Good Fats: *(nuts, seeds, avocado, olive oil)* ____ *Type:* ______________

Other (please specify): ______________

How many **cups** of the following do you typically drink in a day?

____ Tap water

____ Bottled or spring water

____ Coffee

____ Tea

____ Herbal tea

____ Soft drinks *(diet)*

____ Soft drinks *(regular)*

____ Fresh fruit or vegetable juices

____ Fruit or vegetable juices *(prepared)*

____ Milk

____ Red or white wine

____ Beer

____ Other alcoholic beverages

Please indicate how frequently *(1 for rarely, 2 for regularly, 3 for often)* you eat or use:

__ Aluminum pans

__ Microwave

__ Luncheon meats

__ Margarine

__ Artificial sweeteners *(Nutra sweet, Aspartame, Splenda)*

__ Refined foods *(white bread/pasta/rice, pastries, cookies etc.)*

__ Fried foods

__ Candy and chocolate bars

__ Fast foods

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Please provide examples of your typical meals:

Breakfast: ______

Lunch: ______

Dinner: ______

Snacks: ______

What are your favourite foods? ______

How often do you eat them? ______

What food(s) do you crave, and how often do you eat them? ______

Which foods do you dislike? ______

Do you avoid any foods? *Yes / No* If **yes**, which ones and why? ______

______

Do you experience any symptoms if meals are missed? *Yes / No* If **yes**, please explain:

______

Do you experience any symptoms after meals? *Yes / No* If **yes**, please explain:

______

What do you think is contributing to your main health concerns? ______

______

Thank you very much.
All information contained in this form is kept strictly confidential.