

TOTAL LIFE CARE CHARLESTON

New Patient Information ~ Nutrition

Today's Date: _____

PERSONAL INFORMATION:

Patient Name: _____

SSN#: _____

My Email
Address: _____

DOB: _____

Address: _____

CITY: _____

STATE: _____

ZIP: _____

Home
Phone: _____

Work
Phone: _____

Cell
Phone: _____

Sex: **M** or **F**

Spouse/Domestic Partner Name: _____

Not
Married

Spouse/Domestic Partner
Occupation: _____

Spouse /Domestic Partner
Contact #: _____

My Employer: _____

Address: _____

My job
description: _____

Emergency
Contact: _____

Phone #: _____

I was referred
to you through: _____

Pregnant? **Y** or **N**

Last date of
menstruation: _____

Chief complaint (reason you are here): (use separate sheet if more room needed) _____

Previous treatments for this complaint _____

Other complaints or problems: (use separate sheet if needed) _____

HISTORY:

List any major illnesses (with approx. dates) _____

List any surgery or operations (with approx. dates) _____

Past Accidents or injuries: _____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

Do you smoke? No Yes If yes, how many packs _____ (circle frequency) per day/week/month

Drink alcohol? No Yes If yes, type _____ How often? _____ per day/week/month

Do you drink coffee? No Yes If yes, how many (8 oz) _____ (circle frequency) per day/week/month

Do you have soft drinks? No Yes If yes, how many (12 oz) _____ (circle frequency) per day/week/month

Do you ever overeat? No Yes If yes, which foods and how often? _____

Do you have any food allergies, restrictions, or sensitivities? No Yes If yes, to what? _____

Do you get noticeably irritable, lightheaded, or weak if you haven't eaten in a while? No Yes If yes, describe symptoms _____

Please list any food aversions and/or foods you dislike: _____

How often do you eat at home/cook your own meals? Breakfast _____ per day/week/month
Lunch _____ per day/week/month Dinner _____ per day/week/month

Do you crave any of the following frequently?

- | | | |
|---|---|---|
| <input type="checkbox"/> Sweets/ Desserts | <input type="checkbox"/> Meat | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Fish | <input type="checkbox"/> Alcoholic drinks |
| <input type="checkbox"/> Diet Sodas | <input type="checkbox"/> Milk or Cheese | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bread/Pasta | <input type="checkbox"/> Fried Foods | _____ |

Which oils do you use/consume? (Choose all that apply)

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Butter | <input type="checkbox"/> Sesame Oil | <input type="checkbox"/> Soybean Oil |
| <input type="checkbox"/> Margarine | <input type="checkbox"/> Peanut Oil | <input type="checkbox"/> Canola |
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Corn Oil | <input type="checkbox"/> Sun/Safflower |
| <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Crisco | <input type="checkbox"/> Mayonnaise |
| <input type="checkbox"/> Flaxseed Oil | <input type="checkbox"/> Vegetable Oil | <input type="checkbox"/> Other _____ |

How is your dental health? _____

How often do you have bowel movements? _____ per day/week/month Urinate? _____ # times per day
Are your nails weak or brittle? No Yes

Rank the condition of your skin without lotion:

- Very Dry
- Dry
- Normal
- Oily
- Combination

Rank the condition of your hair

- Very Dry
- Dry
- Normal
- Oily
- Dandruff

How often do you exercise? Never Rarely Sometimes Regularly ____x per week Competition

Do you take any nutritional supplements or vitamins? No Yes If yes, which ones? (Be specific. Attach sheet if necessary) _____

Which prescription and over the counter medications do you take currently? (Be specific. Attach sheet if necessary) _____

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

Describe your daily energy levels: _____ Best time of day _____ Worst time of day _____

Please rate the following:

Daily energy level:

- Excellent
- Good
- Fair
- Poor

Energy level after exercise:

- Excellent
- Good
- Fair
- Poor

Daily stress level:

- Very High
- High
- Moderate
- Low
- None

General enjoyment of life

- Excellent
- Good
- Fair
- Poor

Sleep Habits:

How do you sleep: Well Trouble falling asleep Trouble staying asleep Insomnia

How long has this been happening? _____

How many hours do you sleep a night on average? _____

Do night sweats wake you up? No Yes If yes, how often? _____

Do you wake up tired? No Yes If yes, how long has this been happening? _____

Is your room completely dark when you sleep at night? (no night light, street lamp, TV, etc.) No Yes

Do you get at least 30 minutes of outside daylight time, several days each week? No Yes

Please feel free to expand on any concerns you think are important/relevant to your health:

Please check off the Vegetables, Fruits, & Proteins you like or would be willing to eat

(if you don't know what it is, do NOT check it)

Vegetable List

	Alfalfa Sprouts
	Artichoke
	Arugula
	Asparagus
	Beans (black, lima, etc.)
	Beets
	Black eyed peas
	Broccoli
	Brussels sprouts
	Cabbage
	Carrots

	Cauliflower
	Celery
	Chard
	Chives
	Collard greens
	Corn
	Cucumber
	Eggplant
	Endive
	Fennel
	Garlic

	Ginger
	Green beans
	Kale
	Kelp
	Leeks
	Lentils
	Lettuce (romaine, baby greens, etc.)
	Mushrooms
	Mustard greens
	Okra
	Onions
	Parsley
	Parsnips
	Peas

	Peppers (red or green)
	Potato
	Pumpkin
	Radicchio
	Radishes
	Rhubarb
	Rutabaga
	Spinach
	Squash
	Sweet Potato
	Tomato
	Turnips
	Water chestnuts
	Yams
	Zucchini

Fruit List

	Apple
	Apricots
	Avocado
	Banana
	Blackberries
	Blueberries
	Boysenberries
	Cantaloupe
	Cherries
	Crabapples
	Cranberries
	Dates
	Figs

	Grapefruit
	Grapes
	Guava
	Honeydew
	Kiwi
	Lemon
	Lime
	Mandarin
	Mango
	Nectarine
	Orange
	Papaya
	Passion Fruit

	Peach
	Pear
	Persimmon
	Pineapple
	Plum
	Pomegranate
	Prunes
	Raisins
	Raspberries
	Strawberries
	Tangerine
	Watermelon

Proteins

Meats

	Chicken
	Ham
	Beef
	Pork

Dairy

	Eggs
	Cheese
	Yogurt
	Cottage Cheese
	Whey Protein Powder

Fish & Seafood

	Salmon
	Tuna
	Cod
	Grouper
	Sea Bass
	Snapper
	Herring
	Mackerel
	Crab
	Lobster
	Shrimp
	Mussels
	Oysters

	Almonds
	Walnuts
	Brazil Nuts
	Cashews
	Hazelnuts
	Macadamia Nuts
	Pecans
	Pistachio
	Almond Butter
	Cashew Butter
	Sesame Butter

What can we do to make you happier? _____

PERMISSION & AUTHORIZATION FORM

I specifically authorize the natural health practitioners at Total Life Care to perform a nutritional health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease.

I have read and understand the foregoing. This permission form applies to subsequent visits and consultations. I certify that the information contained within this form is correct to the best of my knowledge. I understand that all payments are due at the time of service unless other arrangements have been made.

_____ Date _____

Patient Signature

Print Name

Total Life Care Representative