Alexandria Teed, CCN
Passport 2 Vitality
Email: Alexandria@Passport2Vitality.com

One's health and well-being are influenced by many different things, including lifestyle, family history, emotional health, and nutrition/eating habits.

Instructions: Please complete the following questionnaire to the best of your ability to give us an overall view of your general lifestyle and health habits.

New Patient Nutrition Assessment Form

First Name _____ **Middle Name** _____ **Last Name**_____

Address _____ **City** _____**State**____ **Zip**:_____

Please indicate your preferred method of contact: ☐ home ☐ work ☐ cell ☐ email

Home Phone (_____) _____-_____ **Birth Date** _____ Age _____

Work Phone (_____) _____-_____ **Height**: __′ ___ ″

Cell Phone (_____) _____-_____ **Weight**: _____

Email: _____ **Sex**: _____

Occupation _____ **Blood Type**: A / AB / B / O / Unk

Marital Status _____

Do you have children? ☐ Yes ☐ No **Age(s) of children:**

Are you pregnant? ☐ Yes ☐ No **Due Date** _____

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.) Example: Sarah, age 7,sister _____
_____

Primary Care Provider _____ **Date of last physical exam** _____

Other doctors or practitioners you see _____
_____

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GOALS AND READINESS ASSESSMENT

I would like to visit with Alexandria, today because…

_____
_____
_____

My food and nutrition-related goals are…

_____
_____
_____

My overall, health goals are…

_____
_____
_____

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

1. _____
   _____
2. _____
   _____
3. _____
   _____

The biggest challenge(s) to reaching my nutrition goals is/are:

_____
_____
_____

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

_____
_____
_____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to...	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

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PAST MEDICAL AND SURGICAL HISTORY

Please indicate whether you or your relatives* have been diagnosed with any of the following diseases or symptoms (specify which relative and the date of diagnosis). *Relatives include: parents, grandparents, siblings.

Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe
Allergies (please specify type of allergy)			
Anemia			
Anxiety or Panic Attacks			
Arthritis (osteoarthritis or rheumatoid)			
Asthma			
Autoimmune condition (specify type)			
Bronchitis			
Cancer			
Chronic Fatigue Syndrome			
Crohn's Disease or Ulcerative Colitis			
Depression			
Diabetes (Specify: Type I, II, Prediabetes, Gestational Diabetes)			
Dry, itchy skin, rashes, dermatitis			
Eczema			
Emphysema			
Epilepsy, convulsions, or seizures			
Eye Disease (please specify)			
Fibromyalgia			
Food Allergies or Sensitivities			
Fungal Infection (athlete's food, ringworm, other)			
Gallbladder Disease/Gallstones (specify)			
Gout			
Heart attack/Angina			
Heartburn			
Heart disease (specify)			
Hepatitis			
High blood fats (cholesterol, triglycerides)			
High blood pressure (hypertension)			
Hypoglycemia (low blood sugar)			
Intestinal Disease (specify)			
Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)			
Irritable bowel syndrome			
Kidney disease/failure or Kidney stones			
Lung disease (specify)			
Liver disease			
Mononucleosis			
Osteoporosis			
PMS			
Polycystic Ovarian Syndrome			

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Illness/Disease/Symptom	Self: Age Diagnosed	Relative: Age Diagnosed	Describe/Specify
Pneumonia			
Prostate Problems			
Psychiatric Conditions			
Seizures or epilepsy			
Sinusitis			
Sleep apnea			
Stroke			
Thyroid disease (hypo- or hyperthyroid)			
Urinary Tract Infection			
Other (describe)			
Injuries	**Age**	**Describe/Specify**	
Back injury			
Broken (specify)			
Head injury			
Neck injury			
Other (describe)			
Diagnostic Studies	**Age at study**	**Describe/Specify**	
Barium Enema			
Bone Scan			
CAT Scan: Abdom., Brain, Spine (specify)			
Chest X-ray			
Colonoscopy or Sigmoidoscopy (specify)			
EKG			
Liver scan			
NMR/MRI			
Upper GI Series			
Other (describe)			
Operations	**Age at operation**	**Describe/Specify**	
Dental Surgery			
Gall Bladder			
Hernia			
Hysterectomy			
Tonsillectomy			
Other (describe)			

Please complete the following information concerning your family's health history:

Relative	If Living		If Deceased		Relative	If Living		If Deceased	
	Age	Health	Age at death	Cause		Age	Health	Age at death	Cause
Father					Spouse/Partner				
Mother					Children				
Siblings									

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MEDICAL SYMPTOMS QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile for the past 30 days. If you have been having recent or somewhat severe health symptoms, please indicate that you will fill out the questionnaire for the past 48 hours.

☐ Past 30 days ☐ Past 48 hours

Point Scale

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

Total _____

HEAD

_____Headaches
_____Faintness
_____Dizziness
_____Insomnia

Total _____

EYES

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

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

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

Total _____

MOUTH/THROAT

_____ Chronic cough
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

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

Total _____

HEART

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

Total _____

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LUNGS

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

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINT/MUSCLE

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

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 coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

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

Total _____

GRAND TOTAL _____

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MEDICATION, SUPPLEMENT, AND ANTIBIOTIC INTAKE: Please provide the names of medications, supplements, and/or antibiotics that you are currently taking:

Medication/Supplement/ Antibiotic	Dose	Units	Frequency	Start Date	Stop Date
Example: One-a-Day (brand) Men's Multivitamin	1200	Mg	Daily	08/12/2007	current

Are you allergic to any medications? ☐ Yes ☐ No **Please list:** _____
_____

Please indicate how often you have taken antibiotics during each life stage:

Life Stage	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

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LIFESTYLE

Physical Activity: Using the table, please describe your physical activity.

Activity	Type/Intensity (low-moderate-high)	# Days per week	Duration (minutes)
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-training (weight lifting, pilates, some yoga)			
Sports or Leisure			
Other (specify/describe)			

Does anything limit you from being physically active? _____

Indicate daily stress and rate the level of stress from 1 (extremely low) to 10 (extremely high):
Work_____ Family_____ Social_____ Financial_____ Health_____ Other_____

What helps you to unwind? _____

On average, how many hours of sleep do you get? Weekdays_____ Weekends_____

Do you smoke? ☐ Never ☐ In the past ☐ Currently How long?_____

Alcohol use? ☐ Never ☐ In the past ☐ Currently Type/amount/frequency_____

_____

Drug use? ☐ Never ☐ In the past ☐ Currently ☐ Prefer not to discuss
Type/frequency_____

WEIGHT HISTORY:

Would you like to be weighed today? ☐ Yes ☐ No
Height _____ **Current Weight** _____ **Desired Body Weight** _____
Highest Adult Weight _____ **When?** _____ **Weight 1 year ago** _____
Have you had any recent changes in your weight that you are concerned about? ☐ Yes ☐ No

If yes, please explain:_____

DIGESTIVE HISTORY

Do you associate any digestive symptoms with eating certain foods? ☐ Yes ☐ No

Please explain:_____

How often do you have a bowel movement? _____

If you take laxatives, what type/brand and how often? _____

_____

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Would you describe your stools are hard, soft, or loose? (circle one)

Please indicate how often you experience the following symptoms:

Heartburn	☐ Often	☐ Sometimes	☐ Rarely
Gas	☐ Often	☐ Sometimes	☐ Rarely
Bloating	☐ Often	☐ Sometimes	☐ Rarely
Stomach Pain	☐ Often	☐ Sometimes	☐ Rarely
Nausea / Vomiting	☐ Often	☐ Sometimes	☐ Rarely
Diarrhea	☐ Often	☐ Sometimes	☐ Rarely
Constipation	☐ Often	☐ Sometimes	☐ Rarely

DIET HISTORY

Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious or other)? ☐ Yes ☐ No If so, please describe _____

Please list any food allergies, sensitivities or intolerances _____

_____

Who prepares the majority of your meals? _____ **Who shops for food?** _____

Where do you shop for food? _____

What percent of the foods you eat are… whole ____% organic____% convenience _____%

If you do, how much time do you spend cooking/preparing meals each day? _____

Please indicate the materials you use for cooking and food storage:

☐ Plastic ☐ Glass ☐ Aluminum ☐ Styrofoam
☐ Stainless Steel ☐ Cast-iron ☐ Teflon-non-stick ☐ Ceramic

Do you find cooking difficult? ☐ Yes ☐ No Please describe _____

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 _____)

The nutrition/eating habits that are most challenging for me: _____
_____

The nutrition/eating habits that I am most pleased with: _____
_____
_____

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Beverage Intake: Please indicate 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: ☑ reg ☐ decaf ☐ latte	2 – 8 oz cups	___	___
Water: ☐tap ☐filtered ☐bottled			
Coffee:10 ☐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 _____			

Food Intake: Please indicate the frequency that you eat the following:

How often do you eat:	Never	2-3 times/mo.	1 time/week	2-3 times/week	1 times/day	2-3 time/day
Fast food						
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:						
Soyfoods, type:						
Beans, type:						
Crackers, type:						
Cookies, cakes, muffins						
Whole grains, type:						
Fresh/Raw vegetables						
Cooked vegetables						
Fruit, fresh or frozen						
Canned Vegetables or Fruit						
Margarine						
Dairy (Milk, yogurt, cheese, butter)						
French fries						
Fried meat (chicken, fish)						
Foods with added sweeteners/sugar, type:						
Artificial sweeteners, type:						
Meal Replacements, type:						

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Food cravings _____
_____
_____

Food dislikes _____
_____

Eating Style: Based on how you eat on a regular basis, please check all that apply:

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

The food/nutrition questions that I would like to ask are:

Who may we thank for referring you?