Initial Nutrition Assessment

Please fax or scan completed document to 803-323-5501 / nutrition.cchp@gmail.com 24 hours prior to your scheduled appointment.

Name: _____ Email: _____Date: _____
DOB/Age: _____ Gender: _____ Height: _____ Weight: _____ Desired Weight: _____

How did you hear about us? _____
Reason for consultation: _____

Health & Medical History: Check all that Apply

- ☐ Addiction (coffee/caffeine/cigarettes/ sugar/alcohol/other)
- ☐ ADHD
- ☐ Seasonal Allergies
- ☐ Anxiety/Depression/Mood
- ☐ Arthritis ☐ Osteo ☐ Rheumatoid
- ☐ Asthma
- ☐ Autoimmune Condition: _____
- ☐ Pre-Diabetes ☐ Diabetes
- ☐ Cancer: Type_____
- ☐ Celiac ☐ Gluten intolerance
- ☐ Chronic fatigue syndrome
- ☐ Eating Disorder: _____
- ☐ Fibromyalgia
- ☐ Food allergies or Intolerances
- ☐ GI Condition: _____
- ☐ GERD, Heartburn, Hiatal Hernia
- ☐ Headaches
- ☐ Heart condition
- ☐ High blood pressure /HTN
- ☐ High cholesterol
- ☐ IBD: ☐ Crohn's ☐ Ulcerative colitis
- ☐ Infertility
- ☐ IBS: Type: _____
- ☐ Memory concerns
- ☐ Menopause
- ☐ Neurological Disease: _____
- ☐ Obesity
- ☐ Overweight
- ☐ Osteopenia ☐ Osteoporosis
- ☐ Physical limitation: _____
- ☐ PMS
- ☐ Prostate
- ☐ Sexual dysfunction
- ☐ _____
- ☐ _____
- ☐ _____

Family Health History (obesity, heart disease, hypertension, diabetes, cancer): _____
_____

Digestive function: ☐ Good ☐ Fair ☐ Poor
Bowel Movements: ☐ Daily ☐ < 1x day ☐ 1-2x day ☐ Diarrhea/loose stools ☐ Constipation
Typical energy level: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medications/Supplements (vitamins, minerals, herbs, medical foods)	Dosage	Frequency

Exercise/Activity: ☐ Yes Type: How often? How long?
☐ No Why not?

Sleep: ☐ 8+ hours ☐ 6-8 hours ☐ <6 hours **Sleep Quality:** ☐ Good ☐ Fair ☐ Poor

Occupation: _____

DIET & FOOD HABITS:

Are you aware of any adverse food reactions (allergies/intolerances)? ☐ No ☐ Yes If yes, explain: _____

Do you follow a particular diet/eating pattern? ☐ No ☐ Yes
☐ Vegan ☐ Vegetarian:_____ ☐ Paleo ☐ Low carb ☐ Ketogenic ☐ Gluten Free ☐ Elimination

What percentage of meals do you eat out? ☐ 90-100% ☐ 75% ☐ 50% ☐ < 50% Where? _____

Do you grocery shop? ☐ Yes ☐ No If not, who does? _____

Do you cook? ☐ Yes ☐ No If not, who does? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, what type and how often? _____

Do you smoke? ☐ Yes ☐ No If yes, how often? _____

List any personal challenges to eating well: _____

Balancing Body Chemistry Health Assessment

Please fax or scan completed document to 803-323-5501 / nutrition.cchp@gmail.com 24 hours prior to your scheduled appointment.

Name: _____ Gender: _____ Age: _____ Date: _____

PART I: Circle any of the following medications that you are taking:

- Antacids
- Antibiotic/Antifungal
- Antidepressants
- Antidiabetic/Insulin
- Aspirinz/Tylenol
- Chemotherapy
- Cortisone Anti-inflammatories
- Diuretics
- Heart Medications
- High Blood Pressure/Statins
- Hormones
- Laxatives
- Lithium
- Oral Contraceptives
- Radiation
- Relaxants/Sleeping Pills
- Recreational Drugs
- Thyroid
- Ulcer Mediations
- Other:_____

Circle if you eat, drink or use:

- Alcohol
- Carbonated Beverages
- Juice
- Sweet Tea
- Coffee
- Distilled Water
- Candy
- Cigarettes
- Fast Food
- Fried Foods
- Refined (White) Flour Products
- Deli Meats
- Margarine
- Refined Sugar
- Milk Products
- Artificial Sweeteners
- Smoke/Chew Tobacco
- Vitamins/Minerals
- Specify: _____

PART II: Please read each description and circle the number which best describes the frequency of your symptoms within the past year. **0=Never**, **1=Mild** (occurs once a month or less), **2=Moderate** (occurs several times monthly), **3=Severe** (aware of it almost constantly)

Section A:

1. Bad breath, halitosis ……..0 1 2 3
2. Loss of taste for meat……..0 1 2 3
3. Burning or nervous stomach, eating relieves……..0 1 2 3
4. Gas shortly after eating……0 1 2 3
5. Indigestion ½ to 1 hour after eating, may last 3-4 hours……0 1 2 3
6. Difficulty digesting fruits or vegetables; undigested foods in stools……0 1 2 3
7. Acidic or spicy foods upset stomach……..0 1 2 3

Section B:

8. Lower bowel gas and/or bloating several hours after eating……0 1 2 3
9. Feet burn……..0 1 2 3
10. "Whites" of eyes (sclera) yellow……0 1 2 3
11. Dry skin, itchy feet and/or skin peels on feet……..0 1 2 3
12. Brown spots or bronzing of skin……0 1 2 3
13. Bitter metallic taste in mouth……0 1 2 3
14. Blurred vision……..0 1 2 3
15. Headache over eyes……0 1 2 3
16. Feel nauseous, queasy or gag easily.....0 1 2 3
17. Color of stools light brown or yellow……..0 1 2 3
18. Greasy or high fat foods cause distress.....0 1 2 3
19. Pain between shoulder blades……..0 1 2 3
20. Dark circles under eyes……..0 1 2 3
21. "Acid" breath……..0 1 2 3
22. History of gallbladder attacks, gallstones OR gallbladder removed……0 1 2 3
23. Appetite reduced……0 1 2 3

Section C:

24. Coated tongue or "fuzzy" debris on tongue……0 1 2 3
25. Pass large amounts of foul smelling gas……..0 1 2 3
26. Irritable bowel or mucous colitis……..0 1 2 3
27. Constipation, diarrhea alternating or stools alternate from soft to watery……0 1 2 3
28. Bowel movements painful or difficult, constipation and/or laxatives used……0 1 2 3
29. Burning or itching anus……0 1 2 3

Section D:

30. Head congestion/ sinus fullness……0 1 2 3
31. Sneezing attacks……0 1 2 3
32. Dreaming, nightmare-like bad dreams……..0 1 2 3
33. Milk products and/or wheat products cause distress……0 1 2 3
34. Eyes and nose watery……..0 1 2 3
35. Eyes swollen and puffy……0 1 2 3
36. Pulse speeds after meals and/or heart pounds after retiring……0 1 2 3

Section E:

37. Crave sweets or coffee in afternoon or mid-morning……..0 1 2 3
38. Hungry between meals or excessive appetite……0 1 2 3
39. Overeating sweets……..0 1 2 3
40. Eat when nervous……..0 1 2 3
41. Irritable before meals……..0 1 2 3
42. Get "shaky" or light-headed if meals delayed……0 1 2 3
43. Fatigue, eating relieves……0 1 2 3
44. Heart palpitates if meals missed or delayed……..0 1 2 3
45. Awaken a few hours after sleep, hard to get back to sleep……0 1 2 3

Section F:

46. Muscle soreness after moderate exercise……..0 1 2 3
47. Frequent insect bites (fleas and mosquitoes) ……..0 1 2 3
48. Loss of muscle tone or "heaviness" in arms or legs……..0 1 2 3
49. Enlarged heart and/or heart failure……..0 1 2 3
50. Worrier, feel insecure and/or highly emotional……..0 1 2 3
51. Pulse slow/below 65 or irregular pulse……..0 1 2 3

Name: _____ Gender: _____ Age: _____ Date: _____

Section G:

52. Sex drive increased……..0 1 2 3
53. "Splitting" type headaches……..0 1 2 3
54. Memory failing……..0 1 2 3
55. Tolerance for sugar reduced……..0 1 2 3

Section H:

56. Sex drive reduced or absent……..0 1 2 3
57. Abnormal thirst……..0 1 2 3
58. Weight gain around hips or waist……..0 1 2 3
59. Tendency to ulcers or colitis……..0 1 2 3
60. Increased ability to eat sugar without symptoms……..0 1 2 3
61. Menstrual disorders (women) ……..0 1 2 3

Section I:

62. Difficulty gaining weight, even if large appetite……..0 1 2 3
63. Heart palpitations……..0 1 2 3
64. Nervous, emotional, and/or can't work under pressure…..0 1 2 3
65. Insomnia……0 1 2 3
66. Inward trembling……..0 1 2 3
67. Night sweats……..0 1 2 3
68. Fast pulse at rest……..0 1 2 3
69. Intolerant to high temperatures……..0 1 2 3
70. Easily flushed……..0 1 2 3

Section J:

71. Difficulty losing weight……..0 1 2 3
72. Reduced initiative and/or mental sluggishness……..0 1 2 3
73. Easily fatigues, sleepy during the day……..0 1 2 3
74. Sensitive to cold, poor circulation (cold hands and feet) ...0 1 2 3
75. Dry or scaly skin……..0 1 2 3
76. "Ringing" in ears/noises in head……..0 1 2 3
77. Hearing impaired……..0 1 2 3
78. Constipation……..0 1 2 3
79. Excessive falling hair and/or coarse hair……..0 1 2 3
80. Headaches when awaken/wear off during day……..0 1 2 3

Section K:

81. Blood pressure increased……..0 1 2 3
82. Headaches……..0 1 2 3
83. Hot flashes……..0 1 2 3
84. Hair growth on face or body (females only) ……..0 1 2 3
85. Masculine tendencies (females only) ……..0 1 2 3

Section L:

86. Blood pressure low……..0 1 2 3
87. Crave salt……..0 1 2 3
88. Chronic fatigue/get drowsy……..0 1 2 3
89. Afternoon yawning……..0 1 2 3
90. Weakness/dizziness……..0 1 2 3
91. Weakness after colds/slow recovery……0 1 2 3
92. Circulation poor……..0 1 2 3
93. Muscular and nervous exhaustion……..0 1 2 3
94. Subject to colds, asthma, bronchitis (respiratory disorders) ……..0 1 2 3
95. Allergies and/or hives……..0 1 2 3
96. Difficulty maintaining manipulative correction……..0 1 2 3
97. Arthritic tendencies……..0 1 2 3
98. Nails weak, ridged……..0 1 2 3
99. Perspire easily……..0 1 2 3
100. Slow starter in morning……..0 1 2 3
101. Afternoon headaches……..0 1 2 3

Section M:

102. Frequent skin rashes and/or hives……..0 1 2 3
103. Muscle-leg-toe cramping at rest and/or while sleeping.....0 1 2 3
104. Fever easily raised/fevers common……..0 1 2 3
105. Crave chocolate……..0 1 2 3
106. Hoarseness frequent……..0 1 2 3
107. Difficulty swallowing……..0 1 2 3
108. Joint stiffness after rising……..0 1 2 3
109. Vomiting frequently……..0 1 2 3
110. Tendency to anemia……..0 1 2 3
111. Whites of eyes (sclera) blue……..0 1 2 3
112. Lump in throat……..0 1 2 3
113. Dry mouth-eyes-nose……..0 1 2 3
114. White spots on finger nails……..0 1 2 3
115. Cuts heal slowly and/or scar easily……0 1 2 3
116. Reduced or "lost" sense of taste and/or smell……..0 1 2 3
117. Susceptible to colds, fevers, and/or infections……..0 1 2 3
118. Strong light irritates eyes……0 1 2 3
119. Noises in head or ringing in ears……..0 1 2 3
120. Burning sensations in mouth……..0 1 2 3
121. Numbness in hands and feet (extremities "go to sleep")…0 1 2 3
122. Intolerant to monosodium glutamate (MSG)……0 1 2 3
123. Cannot recall dreams……..0 1 2 3
124. Nose bleeds frequent……..0 1 2 3
125. Bruise easily……..0 1 2 3
126. Muscle cramps, worse with exercise ("charley horses")….0 1 2 3

Section N:

127. Aware of heavy and/or irregular breathing……..0 1 2 3
128. Discomfort in high altitudes……..0 1 2 3
129. "air hunger"/ sigh frequently……..0 1 2 3
130. Swollen ankles/worse at night……..0 1 2 3
131. Shortness of breath with exertion……..0 1 2 3
132. Dull pain in chest and/or pain radiating into left arm, worse on exertion……..0 1 2 3

Section O (female only):

133. Premenstrual tension……..0 1 2 3
134. Painful menses (cramping) ……..0 1 2 3
135. Menstruation excessive or prolonged……0 1 2 3
136. Painful/tender breasts……..0 1 2 3
137. Menstruate too frequently……..0 1 2 3
138. Acne, worse at menses……..0 1 2 3
139. Depressed feelings before menstruation……..0 1 2 3
140. Vaginal discharge……..0 1 2 3
141. Menses scanty or missed……..0 1 2 3
142. Hysterectomy/ovaries removed……0 1 2 3
143. Menopausal hot flashes……..0 1 2 3
144. Depression ……..0 1 2 3

Section P (male only):

145. Prostrate trouble……..0 1 2 3
146. Urination difficulty or dribbling……..0 1 2 3
147. Night urination frequent……..0 1 2 3
148. Pain on inside of legs or heels……..0 1 2 3
149. Feeling of incomplete bowel evacuation……..0 1 2 3
150. Leg nervousness at night……..0 1 2 3
151. Tire easily/avoid activity……..0 1 2 3
152. Reduced sex drive……..0 1 2 3
153. Depression……..0 1 2 3
154. Migrating aches and pains……..0 1 2 3