Nutrition Intake Form Name: _____ Date: _____

Basic Information:

Name: _____ Date of Birth: _____ Age: _____
Address: _____ Phone: _____ (cell/home/office?)
_____ Email: _____
Primary Care Provider: (name) _____ (phone) _____
Emergency Contact: (name) _____ (phone) _____
Referred By: _____ Address: _____
_____ Phone: _____ Fax: _____
Email: _____ OK to provide report? _____
Relationship Status: O single O married Name of Significant Other: _____
Names/Ages of Children: _____
Occupation: _____ Would you like to receive my free nutrition e-newsletter? Yes / No
If yes, please sign up now at the bottom of home page at www.kasiakines.com

Goals for the Appointment: _____
_____
_____ (for more space- continue on page 9)

Detailed Medical History

Please indicate whether any of the following conditions are Past (P), Current (C)

	P	C		P	C		P	C
Abdominal Pain			Crohn's Disease			Liver Disease		
Acne			Depression			Macular Degeneration		
ADD/ADHD			Diabetes I or II			Menopause		
Adrenal Fatigue			Chronic Diarrhea			Mental Illness		
Alcoholism			Difficulty Swallowing			Multiple Sclerosis		
Allergies, foods			Endometriosis			Muscle cramps		
Allergies, other			Epilepsy			Nausea		
Altered/↓ taste			Excessive Gas			Nervousness/Anxiety		
Anemia, Iron			Excessive Thirst			Numb hands or feet		
Anemia, B 12			Fibromyalgia			Organs removed		
Anorexia/Bulimia			Frequent urination			Osteoporosis		
Antibiotics			Gallstones			Parasites		
Last Use: _____			Gastritis			Peptic Ulcer		
Appendicitis			Gastroparesis			Poor appetite		
Arthritis - Rheumatoid			Glaucoma			Post Nasal Drip		
Osteoarthritis			Gout			PMS		
Asthma			Headaches			Psoriasis		
Autoimmune condition			Heart attack			Receding gums		
Bad Breath			Heart arrhythmia			Recreational Drugs		
High Blood Pressure			Hemorrhoids			Sinus problems		
Low Blood Pressure			Hepatitis			Sleep Apnea		
Bronchitis			Herpes			Smoking, # years: _____		
Blood in the stool			High cholesterol			Stroke		
Blurred vision			Hyperthyroidism			Tingling in limbs		
Bruise easily			Hypoglycemia			Unintentional weight gain		
Cancer			Hypothyroidism			Unintentional weight loss		
Candidiasis			IBS			Vaginal itching		
Celiac Sprue			Insomnia			Vaginal infection		
Chronic Fatigue			Kidney disease			Other:		
Constipation			Leg swelling			Other:		

Kasia's notes:

Medical History: Details of **current** medical issues you feel important to explain further:

Year	Month	Diagnosis	Symptoms

Immunizations:

Influenza Pneumonia Malaria Hepatitis Measles Other: _____
Other:_____ Other: _____

Surgeries and Dates:

_____
_____

Allergies to

Medication: _____
Medication: _____
Medication: _____
Food: _____
Food: _____
Food: _____
Other: _____
Other: _____

Type of Reaction

_____
_____
_____
_____
_____
_____
_____
_____

If more allergies, explain here: _____
_____
_____

Environmental Exposure at home:

Furry or feather animals _____
Smoking history _____
Second hand smoking _____
Heating system _____
Type of air conditioning and where _____
Type of water filtration and where _____
Type of air filtration and where _____
Type of basement _____
Type of flooring in the bedroom _____
Type of flooring in the rest of the house _____
Is your bedroom above the garage? _____

Family History

	M	F	Age	Health	If not alive, age at death	Cause of death
Father						
Mother						
Siblings						
Spouse/ Partner						
Children						

Family History: Do you know of any blood relative who has or had the following:

Colon Cancer	ADD or ADHD
Breast Cancer	Environmental Sensitivities
Ovarian Cancer	Dementia
Esophageal Cancer	Parkinson's
Barrett's Esophagus	Epilepsy
Stomach Cancer	Genetic Disorders
Uterine Cancer	Substance Abuse
Pancreatic Cancer	Psychiatric Disorders
Other Cancer:	Depression
High Chol/Triglycerides	Schizophrenia
Heart Disease	Bipolar Disease
High Blood Pressure	Asthma
Obesity	Liver Disease
Diabetes	Kidney Disease
Stroke	Ulcer (duodenal or gastric)
Inflammatory Arthritis (Rheumatoid, Psoriatic)	Food Allergies, Sensitivities or Intolerances
Osteoarthritis	Eczema
Psoriasis	Irritable Bowel Syndrome
Osteoporosis	Celiac Disease
Lupus	Crohn's Disease
Multiple Sclerosis	Ulcerative Colitis
Thyroid Disease	Other Autoimmune:
Migraines	Other:
Autism	Other:

Vitamins, Minerals, Herbs & Other Supplements. Please bring them to the appointment for assessment:

Type	Brand	Dose + Frequency	Start Date	Kasia's notes
e.g. Complete Omega	*Nordic Naturals*	*2 caps a day*	*Aug 2011*	

Kasia's notes on supplements: _____

_____

_____

Lab Results: Write the values and the date of your most recent lab report in 1st column; indicate N (normal), H or L, e.g.: HDL 35 L

	Before 1st appt Lab Date: _____	Lab Date: _____	Lab Date: _____	Lab Date:_____
Glucose				
Hgb A1c				
Bone Density				
Vitamin D				
Total Cholesterol				
HDL				
LDL				
Triglyceride				
Liver enzymes				
Kidney				
C-Reactive Protein				
Homocysteine				
Iron/Ferritin				
Anemia				
Vitamin B12				
Thyroid				
Zinc				
Other:				

Kasia's notes on labs: _____

_____

_____

Current Medications:

Name	Reason	Dose+ Frequency	Start Date	Kasia's notes

Weight History & Digestive Functions

Age: _____ Birthday: _____Height:_____ Current Weight: _____ Weight 6 months ago: _____
Usual Weight: _____Highest Adult Weight: _____ Lowest: _____ Desired Weight Range: _____
Weight Fluctuations (>10 lbs): O yes O no
Digestive Problems: (past) _____
Digestive Problems: (current) _____
Bowel Movement: O 2x/day O1x/day O2x/week O1x/week O other: _____
Stool Consistency: O soft O formed O hard O diarrhea Oconstipation Oother: _____
Stool diameter (circle one): smaller than/ larger than/ same as size of a quarter Stool length in inches: _____
Chewing: O chews on the go O average chewer O chews slowly O chews _____ times per bite

Food & Nutrition History

Have you made any changes in your eating habits? O yes O no Describe: _____
_____
What is your current diet: O Vegetarian O Vegan O Gluten Restricted O No Dairy O Gluten/Casein Restricted
O Weight Loss, describe: _____
O Other: _____
Favorite Foods: _____
Food Dislikes: _____
Foods that make you feel good: _____
Foods that make you feel bad: _____
Foods you avoid as a matter of principle: _____
Foods you crave: _____
Do you wake up hungry at night? O yes O no
Do you compulsively under-eat or overeat (circle if yes)? O yes O no

Check all the factors that apply to your current lifestyle and eating habits:

- O Love to eat
- O Eat too much
- O Erratic eating patterns
- O Time constraints
- O Poor snack choices
- O Challenges obtaining healthy foods
- O Family members/Significant other don't like healthy foods
- O Family members/Significant other have special dietary needs or restrictions
- OConfused about nutrition advice
- O Eat because I have to
- O Emotional eater
- O Late night eating
- O Don't care to cook
- O Travel frequently
- O Fast eater
- O Negative relationships to food
- O Eating in the middle of the night
- O Do not plan meals or menus
- O Reliance on convenience items
- O Food associated with pain

Food Frequency – please be as specific as possible; you may need to abbraviate:

Food/Beverage	Daily	1-2x wk	1-2x mo	Your Comments	Nutritionist's Notes
Fruit: citrus					
Fruit: berries					
Fruit: other – specify					
Fruit: dried					
Fruit Juice: 100%, specify					
Fruit Juice: other, specify					
Raw Vegetables, specify					
Cooked Vegetables, specify					
Vegetable Juice, specify					
Green Drink (powder)					
Peas					
Corn					
Winter Squash					
Sweet Potato					
Other Starchy Vegetables					
Green Leafy Veggies, specify					
Potatoes, white					
Tomatoes					
Bell Pepper					
Eggplant					
Regular Pasta					
Whole Wheat Pasta					
Other Whole Wheat Products					
Barley					
Rye					
Oats					
Kamut					
Spelt					
Bread, rolls, bagels, etc.					
Cereals:↓Sugar,↑High Fiber					
Cereals: High Sugar					
Muffins, cakes, cookies, donuts, etc.					
Gluten Free Pasta					
Other Gluten Free Products					
Millet					
White Rice					
Amaranth					
Quinoa					
Buckwheat					
Corn (grain)					
Beans					
Lentils					
Hummus					

Food/Beverage	Daily	1-2x wk	1-2x mo	Comments	Nutritionist's Notes
Soups: specify brands & kinds					
Veggie Burgers, which brand?					
Soy Foods, specify types					
Eggs					
Egg Whites					
Fish, specify type					
Shellfish					
Poultry					
Red Meat					
Frozen Meals: brands?					
Cheese, specify kinds					
Cottage Cheese					
Ice Cream: brands?					
Frozen Desserts					
Yogurt: specify types					
Skim Milk					
2% Milk					
Whole Milk					
Hemp Milk					
Almond Milk					
Rice Milk					
Protein Powders: which brand					
Energy Bars, specify					
Nuts: types; raw or roasted?					
Seeds: types; raw or roasted?					
Nut Butters: types; raw? Y / N					
Avocado					
Olives					
Cooking Oils: which types?					
Cod Liver Oil					
Flax Seed, ground					
Flax Oil; in fridge? _____					
Hemp oil; in fridge? _____					
Fish oil; in fridge" _____					
Butter: brand; salted? _____					
Margarine/Spreads: brand?					
Salad Dressing-: type + brand					
Mayonnaise					
Mustard					
Ketchup or Salsa					
Soy Sauce or Tamari?					
Chili pepper					
Black Pepper					
Cayenne pepper					
Potato Chips					

Food/Beverage	Daily	1-2x wk	1-2x/mo	Comments	Nutritionist's Notes
Corn Chips					
French Fries					
Pretzels					
Chocolate: milk / dark (circle)					
Candy					
Alcohol – specify					
Regular Coffee (what added?)					
Decaf Coffee					
Regular Tea: brand?					
Decaf Tea					
Herbal Tea – specify					
Regular Soda: specify					
Diet Soda: specify					
Water: bottle/tap/filtered?					
Sweeteners – specify					
Artificial Sweeteners- specify					
Salt – specify					
How much does it matter to if foods are organic or is without or beef is from grass fed cattle wihtout hormones?					

Lifestyle

Stress & Coping

Daily Stressors (rate on a scale of 1-10)

Health: _____ Work: _____ Family: _____ Social: _____ Finances: _____

Other: _____

Hobbies or activities that "recharge" your battery: _____Hrs/week: _____

Stress/Coping Techniques: _____

Sleep Habits

Average hours per night: O >10 O 8-9 O 6-8 O <6 Bedtime: _____ Wakeup: _____

Sleep Concerns: O Insomnia O Awakening O Snoring O Awake un-refreshed O Trouble Falling Asleep

On a scale of 1-10, please rate your energy level (1=lowest, 10=highest): _____

Highs and Lows during the day: _____

Eating Habits

Who shops for food: _____ Where: _____

Who cooks: _____

Number of times eat out: _____x/day, _____x/week Which meals: _____

Favorite places to eat out: _____

Physical Activity

Exercise	Type	Frequency	Duration	Enjoy?
Aerobic				
Strength				
Stretch				
Sports				
Limitations to Exercise:				
Comments:				

Women Only

Age menstruation began: _____ Date of last period: _____
Menstrual cycle: O regular O irregular Cycle Length: _____days
Birth control pills: O yes O no If yes, date started: _____
Labs within last 2 years: O mammogram O pap smear O other: _____
Pregnancy history: _____

Other Comments

Remember to also fill out the forms below, available at www.kasiakines.com under Schedule Appt:

1. Toxicity and Inflammation Questionnaire
2. 3 Day Food Log
3. Waiver
4. Ayurvedic Questionnaire (optional)