Nutrition Health History Questionnaire

Name: _____
Date of Birth: _____ Age: _____
Address: _____
Email: _____Phone #: _____
Emergency Contact Name and #:_____
Relationship to you: _____
Occupation: _____
Children (ages): _____
Gender: _____ Gender Identity: _____
Sexual orientation: _____
Preferred pronoun(s): _____
Relationship Status: _____
How did you hear about us? _____
Pregnant? _____

**Personal Medical History:**
□ Asthma □ Allergies □ Cancer □ Thyroid conditions □ Heart Disease □ Stroke
□ High blood pressure □ Low blood pressure □ Rheumatic fever □ Diabetes: type 1 or 2
□ Other: _____

**Family Medical History:**
□ Asthma □ Allergies □ Cancer □ Thyroid conditions □ Heart Disease □ Stroke
□ High blood pressure □ Low blood pressure □ Rheumatic fever □ Diabetes: type 1, 2
□ Other: _____

**Any areas of life you find stressful?** _____

**Goals and Readiness Assessment:**

**I would like a Nutrition Consultation today because…**

_____
_____

**My food and nutrition-related goals are…**

_____
_____
_____
_____

**My overall health goals are…**

_____
_____
_____
_____

**If I could change 3 things about my health and nutritional habits they would be….**

_____
_____
_____

**Biggest challenges to reaching my nutritional goal(s) is/are:**

_____
_____

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

**Do you know how to read a food label?** Yes No **If no, are you interested in learning?** Yes No

**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….**

| | |
|---|---|
| Significantly modify your diet | 1 2 3 4 5 |
| Take nutritional supplements every day | 1 2 3 4 5 |
| Keep a record of everything you eat each day | 1 2 3 4 5 |
| Modify your lifestyle (ex. work demands, sleep habits, physical activity) | 1 2 3 4 5 |
| Practice relaxation techniques (meditation, qi gong, yoga, acupuncture, reiki, massage) | 1 2 3 4 5 |
| Engage in regular exercise/physical activity | 1 2 3 4 5 |
| Have periodic lab tests with your Primary care physician to assess your progress | 1 2 3 4 5 |

**Medications/Antibiotics:**

| **Name** | **Reason for taking** | **Start/end date** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Significant Trauma/Surgery (accidents/ falls/ gastric bypass, organs removed):**

_____
_____
_____
_____
_____
_____
_____

## Diet History:

**Do you follow any special diet or have dietary restrictions or limitations for any reason (health, cultural, religious, other?)** Yes No If yes, please explain...

_____
_____

**Allergies (seasonal/metals/foods/meds):** _____
_____

**Who prepares the majority of your meals?** _____
**Who food shops for you?**_____
**If you do, how much time do you spend cooking/preparing meals each day?** _____
**Do you find cooking difficult?** Yes No **If yes, why:**
_____
_____

**Do you know how to read a food label?** Yes No **If no, do you want to learn?** Yes No

**Which meals do you eat regularly, check all that apply and detail your regular meals:**
□ Breakfast: _____
□ Lunch: _____
□ Dinner: _____
□ Snacks (times:_____) _____

**What percentage of your food are :**
Home cooked _____ % Organic _____% Convenience _____% Processed _____%

**How often do you eat out/order take out?** 1-2 days/week 3-4 days per week 5-7 days per week

**What nutrition/eating habits do you find most challenging:**

_____
_____

**What nutrition/eating habits are you most pleased with:**

_____
_____

## Food Intake:

**Food Cravings:** □ Sweet □ Salty □ Sour □ Bitter □ Sweet □ Pungent □ Specific food _____

**Food Dislikes:** _____

**Any history of eating disorders?** Yes No
**If yes, please elaborate** _____

**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.) □ Eat too much
□ Late-night eater □ Eat because I have too □ Little/no appetite □ Excess appetite
□ Travel frequently □ Confused about food/nutrition □ Rely on convenience items
□ Time constraints □ Poor snack choices □ Frequently eat fast food □ Love to eat
□ Negative relationship with food □ Family member(s) have different tastes
□ Dislike "healthy" food □ Struggle with eating issues □ Do not plan meals/menus

**Please indicate the frequency that you eat the following foods: (**Example: Fast Food 1x Weekly)

| **Food** | **Never** | **Daily** | **Weekly** | **Monthly** |
|---|---|---|---|---|
| Fast Food | | | | |
| Restaurant Food | | | | |
| Vending Machine Food | | | | |
| Cafeteria/Buffet food | | | | |
| Frozen meals | | | | |
| Home-cooked meals | | | | |
| Leftovers | | | | |
| Beef (hamburger, steak, etc.) | | | | |
| Organ meats (liver, etc) | | | | |
| Lamb | | | | |
| Poultry (chicken, turkey, duck) | | | | |
| Deli meat: _____ | | | | |
| Pork (chop, loin, ham, bacon, etc) | | | | |
| Processed meats (hotdogs, sausage, etc.) | | | | |
| Fish: _____ | | | | |
| Soy Foods: _____ | | | | |
| Beans: _____ | | | | |
| Crackers: _____ | | | | |

| | | | | |
|---|---|---|---|---|
| Cookies, cakes, muffins | | | | |
| Whole grains: _____ | | | | |
| Fresh/Raw/ Cooked veggies | | | | |
| Fruit: fresh or frozen | | | | |
| Canned veggies/ fruit | | | | |
| Margarine | | | | |
| Dairy (milk, yogurt, cheese butter) | | | | |
| Fried Foods (fish, chicken, fries, etc.) | | | | |
| Foods with added sugar/swee | | | | |
| Foods with added sugar/sweeteners: _____ | | | | |
| Foods with added artificial sweeteners:: _____ | | | | |
| Meal Replacements: _____ | | | | |

**Beverage Intake:** Circle the beverage type + mark how much you drink (Ex: Coffee- Decaf 2 cups/day)

| **Beverage** | **Daily** | **Weekly** | **Monthly** |
|---|---|---|---|
| Coffee: Decaf/Regular/Latte | | | |
| Water: tap, filtered, bottled, seltzer | | | |
| Tea: Type _____ | | | |
| Juice: Type _____ | | | |
| Soda: regular, diet | | | |
| Milk: whole, 2%, 1%, Skim | | | |
| Milk alternative: soy, rice, almond, lactaid | | | |
| Alcohol: wine, beer, liquor | | | |
| Other: _____ | | | |

## Lifestyle:

**Physical Activity:** Using the table, please describe your physical activity, put N/A if not applicable

| Activity type | Intensity type: low- moderate-high | # Days per week | Duration (minutes) |
|---|---|---|---|
| Stretching/Yoga | | | |

| | | | |
|---|---|---|---|
| Aerobics/Cardio (walking, joking, biking, etc.) | | | |
| Strength-training (wt. lifting, pilates, some yoga) | | | |
| Sports or Leisure type: _____ | | | |
| Other: _____ | | | |

Does anything limit you from being physically active?

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high)
Work _____ Family _____ Social _____ Financial _____ Health _____ Other _____

What helps you unwind? _____
_____
_____

**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 recent changes in your weight that you are concerned about? Yes No
If yes, Please Explain: _____
_____

**Digestive Health:**

□ gas □ bloating/ edema □ acid reflux/ GERD □ fatigue after meals □ belching □ nausea

□ vomiting □ eating disorders □ binge eating □ IBS/ Crohn's disease □ food stagnation

□ excessive appetite □ poor appetite □ black stools □ blood in stools □ bypass surgery

□ abdominal cramps □ indigestion □ rectal pain □ abdominal pain/cramping □ bad breath

□ bleeding gums □ hemorrhoids □ slow digestion □ chronic laxative use

□ loose stools, more than 2/day □ any other Stomach/intestinal issues: _____

**Bowel Movements:** Circle all that apply
**Tend towards:** constipation, diarrhea, normal stools
**How many Bowel Movements per day/week:** _____
**Qualities:**
Loose, Formed, Loose-formed, 'Snake-like' stools, 'Goat' stools (pebbles), Other: _____
Easy to pass, Feels complete, Difficulty Passing, Incomplete sensation
Foul Odor
Undigested Food
Burning, Straining, Pain
Blood in stools
Black Stools
Floating stools

## Chinese Medicine Assessment: Mark all that apply in all categories

**Qi Deficiency:**

LUNG:
□ Breathlessness
□ Weak Voice
□ Spontaneous Sweating
□ weak cough
□ lack desire to talk
□ easily catch colds
□ bright white complexion

HEART:
□ Palpitations
□ Shortness of Breath on exertion

KIDNEY:
□ Frequent Urination
□ Possible Lower Back Pain and Weak Knees
□ Possible Poor Memory

SPLEEN:
□ Loss of Appetite/decreased appetite
□ Loose Stools
□ Fatigue
□ weak limbs
□ Normal or Pale and Swollen Tongue

GENERAL:
□ Lassitude
□ fatigue
□ pallor/sallow complexion

**Blood Stagnation:**

□ Stabbing fixed pain
□ Dark complexion
□ Purple lips and nails
□ Dark blood and clots if there is bleeding
□ Pulse: Wiry or Choppy

Tongue:
□ Red purple (Heat)
□ Blue purple (Cold)
□ Possible purple or red spots

**Qi Stagnation:**

□ Pain in the Area of Stagnation
□ A Feeling of Oppression
□ Distention and Bloating
□ Depression, Irritability, Melancholy, Moodiness
□ Frequent Sighing
□ Chest stuffiness
□ Restless leg syndrome
□ Hypochondria distention

□ Sensation of foreign object in throat
□ Difficulty swallowing
□ PMS and irritability
□ Irregular menstruation and dysmenorrhea

□ Wiry Pulse
□ Possible Purple Tongue

**Yang Deficiency:**

KIDNEY:
□ Pallor
□ cold limbs
□ soreness and weakness of lumbar region and knee joints
□ impotence
□ infertility
□ dizziness
□ tinnitus
□ pulse: deep and weak
□ tongue: pale white coating

SPLEEN:
□ Feeling cold, cold limbs
□ Slight abdominal distention after eating which becomes more pronounced as the condition worsens
□ Tiredness
□ Pale complexion
□ Weakness of the limbs
□ Loose stools to watery stools
□ Nausea and vomiting,
□ Loss of appetite
□ Abdominal pain that can be sharp at times
□ Pale tongue with a white coating
□ Tendency to obesity
□ Edema

**Yin Deficiency:**

Kidney:
□ Afternoon or evening sweats, night sweats

□ Hot flashes
□ Dry mouth or throat

□ Thirst
□ Feeling of fever in afternoon or evening
□ Tinnitus- constant ringing in ears
□ Achy lower back
□ Aching bones
□ Weakness of knees or lower back

Kidney-Liver:
□ Dry eyes, vision impairment
□ Joint stiffness
□ Headaches
□ Tinnitus-comes and goes
□ Nervousness
□ Short temper

Kidney-Heart:
□ Poor memory

□ Palpitations
□ Irritability
□ Easily startled
□ Waking frequently through the night
□ Excessive Dreaming
□ Dispirited
□ Anxious, especially at night
□ Emotional disorders
□ Heightened libido possibly with nocturnal emissions

**Blood Deficiency:**
LIVER:
□ Slight tremor
□ floaters in eyes
□ dry eyes
□ night blindness
□ spasms in tendons
□ cramps

GENERAL:
□ withered/brittle nails
□ dry hair and skin
□ poor memory

□ anxiety
□ tendency to be startled
HEART:
□ Sallow or "dull white" complexion
□ Poor memory
□ Insomnia (problems falling asleep)
□ Dizziness and Vertigo
□ Numbness of limbs
□ Blurred vision
□ Pale Lips
□ scanty menstruation or amenorrhea

**Essence Deficiency:**
Children:
□ slow physical or mental development
□ late or incomplete fontanel closure
□ poor general skeletal development

Adults:
□ premature aging and sentility
□ bad teeth
□ poor memory
□ brittle bones
□ weak knees and legs
□ sore back
□ sexual disfunction

**Dampness:**
General:
□ Copious turbid, cloudy or sticky excretions and secretions
□ Leucorrhea or heavy vaginal discharge
□ Chronic sinusitis
□ candida
□ Aversion to drinking, even with thirst
□ Trouble waking in morning
□ Symptoms worsen with wet weather
□ Sticky or watery bowel movement, or chronic diarrhea
□ Feeling of heaviness in the body, especially in the abdomen
□ heaviness of the head/body

□ excessive mucus
□ foggy head

Internal Wind Damp Cold -
□ migrating arthritic pains,
□ rashes moving from place to place
□ pain moving from joint to joint

Cold-Damp:
□ aversion to the cold
□ slowed metabolism
□ stiffness and soreness in the muscles and joints (osteo-arthritis)
□ clear or white discharges and phlegm

Damp-Heat
□ redness, swelling, blisters
□ UTI's with burning pain,
□ thick yellow/green phlegm, sticky yellow coat on tongue,
□ rashes with redness and discharge
□ sores with puss
□ strong odors
□ painful acne with redness and puss; herpes shingles are good examples as well as itchy, weepy psoriasis or eczema.

**NUTRITIONAL COUNSELING INFORMED CONSENT TO TREAT**

I hereby authorize **On Point Acupuncture & Wellness Staff** to perform and/or order procedures that include but may not be limited to the following in order to facilitate my diagnosis and treatment:

**General Diagnostic Procedures-** Including but not limited to height and weight measurements, physical examination (tongue, pulse, etc.), Gene SNP testing, pH testing, Blood work

**Psychological Counseling, Lifestyle Counseling, and Exercise Prescriptions, Herbs and Supplements-** Prescribing of various therapeutic substances including plant remedies, vitamins and minerals, amino acids. Substances may be given in the form of teas, pills, powders, and tinctures that may contain alcohol; topical creams, essential oils, homeopathic remedies, flower essences, and suppositories; other medicines may be used.

**Dietary Advice and Therapeutic Nutrition-** use of foods, dietary suggestions or nutritional supplements for treatment.

**Potential risks of any medical treatment:** Pain, discomfort, infection, loss of consciousness or allergic reactions to prescribed herbs or supplements; changes in bowel movements and digestive health and aggravation of pre-existing symptoms.

**Notice to pregnant and breastfeeding patients:** All patients who know or suspect that they are pregnant and/or breastfeeding must alert **On Point Acupuncture & Wellness Staff** since some of the therapies used could present a risk to the pregnancy and/or breastfeeding infant.

I hereby request and consent to the performance of nutritional counseling treatments and other procedures within the scope of the practice of acupuncture and nutritional counseling on me (or on the patient named below, for whom I am legally responsible) by the licensed health practitioners who now or in the future, treat me while employed by, working or associated with **On Point Acupuncture & Wellness**, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to: recommendations regarding nutritional habits, physical activity and supplementation. There is no obligation to implement the recommendations and alternative treatment may include no treatment.

I understand that acupuncturists practicing in the State of Massachusetts are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner(s). I understand that I may be asked to do routine blood work with my primary care physician in order to monitor vitamin and nutrient deficiencies in my body and track progress with any dietary and supplementation suggested and/or implemented as a result of my nutrition consultation at **On Point Acupuncture & Wellness**. I understand that it is my responsibility as a patient to check with my primary care doctor prior to beginning any new supplementation or diet program to avoid drug interactions or complications with any pre-existing care plan.

I will notify a clinical staff member immediately if I have any adverse reactions or concerns with treatment, dietary advice and supplementation. I will notify a clinical staff member who is caring for me if I am or become pregnant. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records, but all my records will be kept confidential and will not be released without my written consent.

I, the undersigned, hereby expressly and affirmatively state that I wish to participate in nutritional counseling. I realize that my participation in this activity involves risks of injury including but not limited to: cardiovascular and orthopedic type injuries, serious disabling injuries, and even the possibility of death. I also recognize that there are many other risks of injury that may arise due to my participation in this activity, and that it is not possible to specifically list each and every individual injury risk. However, knowing the material risks and appreciating, understanding, and anticipating that other injuries and even death are a possibility, I hereby expressly assume all of the delineated risks which could occur by reason of my participation. I have had an opportunity to ask questions. Any questions I have asked have been answered to my complete satisfaction. I subjectively understand the risks of my participation in this activity, and I voluntarily choose to participate, assuming all risks due to my participation.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date: _____
Print Name:_____
Relationship: Self / Parent / Guardian (circle)
Practitioner's Signature: _____ Date: _____