Select Chiropractic and Wellness
6010 Hidden Valley Rd, Ste 107
Carlsbad, CA 92011

Nutrition Patient Intake Form

www.selectchirowellness.com
(760) 893-6459

Confidential Patient Information

Patient's Name: _____ Today's Date: _____

Date of Birth: ____ / ____ / ____ Age: ____ Gender: M / F / Other Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (H): _____ (W): _____ (C): _____

E-Mail Address: _____

Communication Preference: ___ E-Mail ___ Phone ___ Mail ___ Fax

Emergency Contact: _____ Phone: _____

Relation to Patient: _____

Occupation: _____ (Circle one): Part-Time / Full- Time / Retired

Employer: _____

Marital Status: ___ Single ___ Married ___ Widowed ___ Separated ___ Divorced

Spouse's Name: _____ # of Children ___

Race (Circle One): American Indian or Alaskan Native / Asian / Black or African American /
White (Caucasian) / Hawaiian Native or Pacific Islander / Decline to Answer
Other: _____

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Preferred Language: ___ English ___ Other: _____

Primary Care Physician: _____ Phone: _____

___ Please do not share the results of this visit with this provider

Whom may we thank for referring you to our practice?: _____

Patient Name: _____ Date: _____

HEALTH HISTORY

Main condition/symptom: _____

_____

Other conditions/symptoms: _____

How long have you had these conditions/symptoms: _____

Have you seen any other health care providers for this? (Circle One): YES / NO

If yes, who? When?

1. _____
2. _____
3. _____

Have you seen a nutritionist before? (Circle One): YES / NO

Date of last physical exam? _____ Date of last blood work? _____

Height: ___ ft ____ in Weight: _____

Have you recently gained weight unexpectedly? (Cirlce One): YES / NO

Have you recently lost weight unexpectedly? YES / NO

Would you like to weigh more or less than you do now? YES / NO _____

Last known blood pressure: _____ / ____ mmHg Date: _____

Have you ever been diagnosed with Hypertension? (Circle One): YES / NO

If yes, when were you diagnosed? _____ Are you currently taking medicine for it?: YES / NO

Have you ever been diagnosed with Diabetes?: YES / NO If yes, what type: TYPE I / TYPE II

If yes, when were you diagnosed? _____ Are you currently taking medicine for it?: YES / NO

Current Medications: Please list all prescriptions, over-the-counter medicines, and supplements. Please also include dosage (if known) and frequency.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies: Please list any allergies to medications and foods that you have and your reaction.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient Name: _____ Date: _____

Review of Body Systems (Circle if you HAVE, HAD, or DENY any of the listed conditions)

MUSCULOSKELETAL

Osteoporosis: HAVE / HAD / DENY
Arthritis: HAVE / HAD / DENY
Muscle Pain: HAVE / HAD / DENY
Weakness: HAVE / HAD / DENY
TMJ Issues: HAVE / HAD / DENY
Other: _____

NEUROLOGICAL

Anxiety: HAVE / HAD / DENY
Depression: HAVE / HAD / DENY
Headache: HAVE / HAD / DENY
Dizziness: HAVE / HAD / DENY
Pins / Needles: HAVE / HAD / DENY
Numbness: HAVE / HAD / DENY
Seizures: HAVE / HAD / DENY
Other: _____

SENSORY

Blurred Vision: HAVE / HAD / DENY
Ringing in Ears: DENY
Hearing Loss: HAVE / HAD / DENY
Loss of Smell: HAVE / HAD / DENY
Lost of Taste: HAVE / HAD / DENY
Other: _____

CONSTITUTIONAL

Fainting: HAVE / HAD / DENY
Low Libido: HAVE / HAD / DENY
Poor Appetite: HAVE / HAD / DENY
Fatigue: HAVE / HAD / DENY
Other: _____

CARDIOVASCULAR

Hypertension: HAVE / HAD / DENY
Hypotension: HAVE / HAD / DENY
High Cholesterol: HAVE / HAD / DENY
Bad Circulation: HAVE / HAD / DENY
Angina: HAVE / HAD / DENY
Frequent Bruising: HAVE / HAD / DENY
Stroke: HAVE / HAD / DENY
Other: _____

RESPIRATORY

Asthma: HAVE / HAD / DENY
Apnea: HAVE / HAD / DENY
Emphysema: HAVE / HAD / DENY
COPD: HAVE / HAD / DENY
Hay Fever: HAVE / HAD / DENY
Shortness Breath: HAVE / HAD / DENY
Pneumonia: HAVE / HAD / DENY
Other: _____

ENDOCRINE

Hyperthyroid: HAVE / HAD / DENY
Hypothyroid: HAVE / HAD / DENY
Immune Disorders HAVE / HAD / DENY
Hypoglycemia: HAVE / HAD / DENY
Metabolic Synd.: HAVE / HAD / DENY
Swollen Glands: HAVE / HAD / DENY
Low Energy: HAVE / HAD / DENY
Other: _____

DIGESTIVE

Anorexia: HAVE / HAD / DENY
Bulimia: HAVE / HAD / DENY
Disordered Eating: HAVE / HAD / DENY
Ulcer: HAVE / HAD / DENY
Food Sensitivities: HAVE / HAD / DENY
Heartburn: HAVE / HAD / DENY
Constipation: HAVE / HAD / DENY
Diarrhea: HAVE / HAD / DENY
Other: _____

INTEGUMENTARY

Skin Cancer: HAVE / HAD / DENY
Psoriasis: HAVE / HAD / DENY
Eczema: HAVE / HAD / DENY
Acne: HAVE / HAD / DENY
Swollen Glands: HAVE / HAD / DENY
Rash: HAVE / HAD / DENY
Other: _____

GENITOURINARY

Kidney Stones: HAVE / HAD / DENY
Infertility: HAVE / HAD / DENY
Bedwetting: HAVE / HAD / DENY
Prostate Issues: HAVE / HAD / DENY
Erectile Dysfxn: HAVE / HAD / DENY
PMS Symptoms: HAVE / HAD / DENY
Other: _____

Do you have any additional health conditions not listed above? If yes, please list below.

Condition: _____ HAVE / HAD
Condition: _____ HAVE / HAD
Condition: _____ HAVE / HAD
Condition: _____ HAVE / HAD

Patient Name: _____ Date: _____

Hospitalizations: Please list the date(s) and reason(s) for any hospitalizations.

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Surgeries: Please list the date(s) and surgical procedure(s) you've had.

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Other Injuries: Please list any other injuries not described above.

_____

_____

_____

Family Medical History Check the box for any family member affected by the conditions listed

Diagnosis	Father	Mother	Sibling (brother or sister)	Offspring (son or daughter)
Heart Disease				
Hypertension				
Diabetes (Specify Type)				
Cancer (Specify Type)				
Other:				
Other:				

Social History Check all that apply

Who do you live with: ____ Alone ____ Spouse ____ Other

Alcohol consumption: ____ Never ____ Casual ____ Moderate ____ Excessive
____ Wine ____ Beer ____ Hard Alcohol

Coffee consumption: ____ Never ____ 1-2 per day ____ 3-6 per day ____ 7 or more

Soda consumption: ____ Never ____ 1-2 per day ____ 3-6 per day ____ 7 or more

Water consumption: ____ 0-2 per day ____ 3-5 per day ____ 6-8 per day ____ 9 or more

Smoking: ____ Never ____ Former ____ Every day ____ Sometimes
Smoking Start Date:
Smoking End Date:

Rate Interest in Quitting: None 1 2 3 4 5 6 7 8 9 10 Very Interested

Recreational Drugs: ____ None ____ Sometimes ____ Addiction

Patient Name: _____ Date: _____

Social History (Continued)

Rate your PHYSICAL stress level: NONE 1 2 3 4 5 6 7 8 9 10 LOTS OF STRESS

Rate your EMOTIONAL stress level: NONE 1 2 3 4 5 6 7 8 9 10 LOTS OF STRESS

What are the major stressors in your life? _____

Meals eaten daily:	____ 1	____ 2	____ 3	____ 4 or more
Do you skip breakfast regularly?	____ No	____ Yes		
Do you snack between meals?	____ No	____ Yes		
If yes, when do you snack?	____ Never	____ late AM	____ early PM	____ late PM
Daily Servings of Vegetables:	____ None	____ 1-2 per day	____ 3-4 per day	____ 5 or more
Daily Servings of Fruits:	____ None	____ 1-2 per day	____ 3-4 per day	____ 5 or more
Daily Servings of Protein:	____ None	____ 1-2 per day	____ 3-4 per day	____ 5 or more
Daily Servings of Nuts:	____ None	____ 1	____ 2	____ 3 or more
Daily Servings of Grains:	____ None	____ 1-2 per day	____ 3-6 per day	____ 6 or more
How often do you eat fast food?	____ Never	____ 1-2 per wk	____ 3-4 per wk	____ 5 or more
How often do you eat dessert?	____ Never	____ 1-2 per wk	____ 3-4 per wk	____ 5 or more

Rate your eating habits: UNHEALTHY 1 2 3 4 5 6 7 8 9 10 HEALTHY

Hours of sleep per night:	____ 1-3 hours	____ 4-6 hours	____ 7-9 hours	____ 10+ hours
Is it easy to fall asleep?	____ No	____ Yes		
Is it easy to stay asleep?	____ No	____ Yes		
Do you wake up in the night?	____ No	____ Yes		
If yes, how many times?	____			
Is it at the same time every night?	____ No	____ Yes, around _____		

How often do you exercise a week?	____ Never	____ 1-3 times	____ 4-7 times	____ 8+ times
Types of exercise performed:	____ Walking	____ Running	____ Swimming	____ Biking
	____ Weightlifting	____ CrossFit	____ Surfing	____ Rowing
	____ Yoga	____ Pilates	____ Aerobics	____ Plyometrics
	____ Other: _____		____ Other: _____	
	____ Other: _____		____ Other: _____	

Do you have any additional health goals?

_____

_____

_____

_____

Patient Name: _____ Date: _____

Nutritional Familiarity

Do you feel comfortable with placing foods in food groups? ____ No ____ Yes

Do you feel comfortable assessing the serving size of a food group? ____ No ____ Yes

Do you understand food labels well? ____ No ____ Yes

Are there any foods you do not like? ____ No ____ Yes

If yes, which ones? _____

What's your favorite food? _____

Do you like to cook? ____ No ____ Yes

How much time do you have to prepare foods? _____

Have you tried any particular diets in the past? ____ No ____ Yes

If yes, which one(s)? _____

If yes, did any of them work well for you? ____ No ____ Yes

_____

Use this space to write down any additional questions, comments, concerns.

Patient Signature: _____ Date: _____