Beth Winter, CNTP, MNT
beth@vitalnutritionforhealth.com
801-597-0386

HEALTH HISTORY INTAKE FORM

*Please email a scanned copy of your completed Health History Intake Form to beth@vitalnutritionforhealth **at least** **(3) days prior** to your first appointment. This allows us to fully process your information and prepare your comprehensive holistic health plan. Thank you!*

Date_____

Name_____Date of Birth_____

Address_____

Where did you grow up?_____

Email_____

Phone _____

How do you prefer to be contacted? _____

Sign up for our e-newsletter (nutrition news, tips, events and recipes)? _____

Age_____ How old do you feel? _____

Weight_____Height _____

Marital status (single, in a relationship, married, divorced, widowed)_____

Do you have children? _____If so, how old are they?_____

Occupation_____Do you enjoy your job?_____

Employer_____
Employment Status: _____Full Time ____Part Time _____Retired (when?)____ Student _____

Who is your physician?_____

How did you hear about my services? _____

Please list your main health concerns (in order of importance)
1._____

2._____

3._____

4._____
What would you like to change or improve?

_____

Did something trigger the change in your health?

_____

What are your expectations for seeking nutritional therapy?

_____

HEALTH HISTORY

Please provide a brief history of your health. Include any previous surgeries and past or present illnesses, hospitalizations, or discomforts.

_____

_____

_____

_____

_____

Which health practitioners and doctors do you see? (list names, locations)

_____

_____

Have you gained or lost a significant amount of weight in the past? _____

When? _____ How much? _____

List the dietary and herbal supplements you take, with dosages:

_____

_____

_____

_____

List the over-the-counter medications and prescriptions you take, with dosages:

_____

_____

_____

_____

Do you have any allergies? If so, to what?

_____

How was your health as a child? List any conditions:

_____

_____

Were you breast fed?_____ Formula-fed? _____ Delivered vaginally or by caesarean?_____

What did your parents teach you about food?_____

_____

DIGESTION AND ELIMINATION HEALTH & HISTORY

How frequent are your bowel movements?_____# times for day or week

COLON HEALTH

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Diarrhea	0 1 2 3	Loose, unformed stool	0 1 2 3
Constipation	0 1 2 3	Hard, small stool	0 1 2 3
Strain to eliminate	0 1 2 3	Urgency to eliminate	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3	Incomplete bowel emptying	0 1 2 3
Recurrent colds and infections	0 1 2 3	Laxative use	0 1 2 3
Blood or mucus in stool	0 1 2 3	Excessive gas	0 1 2 3
Bloating	0 1 2 3	Lower abdominal cramps -	0 1 2 3
Antibiotic use	0 1 2 3	alleviated by passing gas or stool	
Toe or fingernail fungus	0 1 2 3		

HYPOACIDITY OF STOMACH

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Excessive burping	0 1 2 3	Feeling overly full after meals	0 1 2 3
Bloating	0 1 2 3	Gas immediately after a meal	0 1 2 3
Offensive breath	0 1 2 3	Undigested foods in stool	0 1 2 3
Protein feels like it sits in stomach	0 1 2 3	Poor appetite	0 1 2 3
Stomach is easily upset	0 1 2 3	Known food allergies	0 1 2 3
History of constipation	0 1 2 3	Nausea after taking supplements	0 1 2 3

Iron-deficiency anemia	0 1 2 3	Foul smelling gas	0 1 2 3

HYPERACIDITY OF STOMACH

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Stomach pain, burning 1-4 hrs after meals	0 1 2 3	Stomach pain before meals	0 1 2 3
Antacid or proton pump inhibitor use	0 1 2 3	Hungry 1-2 hrs after meals	0 1 2 3
Heartburn when lying down	0 1 2 3	Relief from antacids, foods or drinks	0 1 2 3
Digestive problems-subside with resting	0 1 2 3	Heartburn from certain foods	0 1 2 3
Burping	0 1 2 3	Use of or NSAIDS (aspirin)	0 1 2 3
Family history of ulcers or gastritis	0 1 2 3	Current ulcer	0 1 2 3

INTESTINAL PERMEABILITY

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Constipation	0 1 2 3	Diarrhea	0 1 2 3
Abdominal pain or bloating	0 1 2 3	Joint pain or swelling, arthritis	0 1 2 3
Frequent fatigue	0 1 2 3	Food allergy, sensitivity, intolerance	0 1 2 3
Sinus or nasal congestion	0 1 2 3	Eczema or psoriasis	0 1 2 3
Hives	0 1 2 3	Skin rashes	0 1 2 3
Asthma	0 1 2 3	Seasonal allergies or hay fever	0 1 2 3
Poor memory	0 1 2 3	Mood swings	0 1 2 3
Use of NSAIDS (aspirin, Tylenol, ibuprophen)	0 1 2 3	History of antibiotic use	0 1 2 3
Alcohol makes you feel sick	0 1 2 3	Ulcerative colitis, Crohn's, Celiac	0 1 2 3
Headaches	0 1 2 3	Migraines	0 1 2 3

LIVE AND GALLBLADDER HEALTH

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Intolerance to fatty/greasy foods	0 1 2 3	Headaches after eating	0 1 2 3
Light colored stool	0 1 2 3	Stools that float	0 1 2 3
Less than 1 bowel movement daily	0 1 2 3	Sour taste in mouth	0 1 2 3
Fatigue after eating	0 1 2 3	Gray-colored skin	0 1 2 3
Yellow in whites of eyes	0 1 2 3	Pain when passing stool	0 1 2 3
Dry skin or hair	0 1 2 3	Acne	0 1 2 3
Triglyceride level above 115	0 1 2 3	Total cholesterol above 200	0 1 2 3
Bumps on back of arms	0 1 2 3	PMS symptoms	0 1 2 3
Keratosis	0 1 2 3		

HYPOFUNCTION OF SMALL INTESTINES AND OR PANCREAS

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Abdominal cramps	0 1 2 3	Fatigue after eating	0 1 2 3
Constipation from eating fiber	0 1 2 3	Three or more large BMs daily	0 1 2 3

Acne	0 1 2 3	Food allergies	0 1 2 3
Difficulty gaining weight	0 1 2 3	Gallstones/Gallbladder disease	0 1 2 3
Nausea	0 1 2 3	Intolerance to probiotic suppl	0 1 2 3
Restless leg syndrome	0 1 2 3		

Do certain foods tend to aggravate these issues? Which foods/ issues?

_____

Do you suspect you have food allergies or sensitivities? If so, to what? _____

_____

Past foreign travel? _____ Where? _____ When? _____
Where? _____ When? _____
Where? _____ When? _____

When was the last time you were on antibiotics? _____

What were they prescribed for? _____

BLOOD SUGAR BALANCE

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Crave sweets during the day	0 1 2 3	Heart palpitations if skip meals	0 1 2 3
Irritable if skipped meals	0 1 2 3	Headache, lightheaded if skip meals	0 1 2 3
Rely on coffee or soda in morning/afternoon	0 1 2 3	Eating relieves fatigue	0 1 2 3
Feel shaky, jittery or have tremors	0 1 2 3	Agitated, easily upset, nervous	0 1 2 3
Poor memory, forgetful	0 1 2 3	Blurred vision	0 1 2 3
Wake at night and can't fall back to sleep	0 1 2 3	Have to eat in middle of night	0 1 2 3
Fatigue after meals	0 1 2 3	Sweet cravings not satisfied	0 1 2 3
Crave sweets after meals	0 1 2 3	Waist girth is larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3	Increased thirst	0 1 2 3
Always hungry	0 1 2 3	Difficulty losing weight	0 1 2 3
Excessively weak for no reason	0 1 2 3	Get sleepy or tired after lunch	0 1 2 3

NUTRIENT DEFICIENCIES

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Bruise easily	0 1 2 3	Cannot recall dreams	0 1 2 3
Numbness in hands or feet	0 1 2 3	Muscle cramping while at rest/sleep	0 1 2 3
Strong light irritates eyes	0 1 2 3	Crave chocolate	0 1 2 3
Anemia	0 1 2 3	White spots on fingernails	0 1 2 3
Reduced sense of taste/smell	0 1 2 3	Susceptible to colds, infections	0 1 2 3

MOUTH HEALTH & HISTORY

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Canker sores	0 1 2 3	Cold sores	0 1 2 3
Gum disease/infections	0 1 2 3	Bleeding gums	0 1 2 3
Root canals	0 1 2 3		

How many times per week do you floss? _____

Have your wisdom teeth been taken out? _____ Have any other teeth been extracted? _____

HEAD / FACE HEALTH & HSTORY

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Post nasal drip	0 1 2 3	Hair loss	0 1 2 3
Dry eyes	0 1 2 3	Watery eyes	0 1 2 3
Dark circles under eyes	0 1 2 3	Eye twitches	0 1 2 3
Ear infections	0 1 2 3	Night blindness	0 1 2 3
Glaucoma	0 1 2 3	Cataracts	0 1 2 3
Vertigo	0 1 2 3		

CARDIOVASCULAR HEALTH & HISTORY

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

High blood pressure	0 1 2 3	Low blood pressure	0 1 2 3
Arrhythmias	0 1 2 3	Palpitations	0 1 2 3
Murmurs	0 1 2 3	Edema	0 1 2 3
Chest pain	0 1 2 3	Atherosclerosis	0 1 2 3

URINARY TRACT HEALTH & HISTORY

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Incontinence	0 1 2 3	Pain with urination	0 1 2 3
Kidney stones	0 1 2 3	Urinary tract infections	0 1 2 3
Discharge/blood in urine	0 1 2 3	Urgency	0 1 2 3
Foul smelling urine	0 1 2 3	Dark colored urine	0 1 2 3

NERVOUS SYSTEM & HISTORY

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Carpal tunnel	0 1 2 3	Seizures	0 1 2 3
Tingling or numbness	0 1 2 3	Fainting	0 1 2 3

ADRENAL FUNCTION

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Cannot stay asleep	0 1 2 3	Cannot fall asleep	0 1 2 3
Slow starter in the morning	0 1 2 3	Afternoon fatigue	0 1 2 3
Dizzy when standing quickly	0 1 2 3	Afternoon headaches	0 1 2 3
Weak or ridged fingernails	0 1 2 3	Low blood pressure	0 1 2 3
Slow recovery from colds	0 1 2 3	Poor circulation	0 1 2 3

Susceptible to respiratory infections	0 1 2 3	Difficulty holding chiropractic adj	0 1 2 3
Cravings for salt	0 1 2 3	Perspire easily	0 1 2 3
Under a lot of stress and often	0 1 2 3	Weight gain when stressed	0 1 2 3
Wake tired after 6+ hrs of sleep	0 1 2 3	Hot flashes	0 1 2 3
Low sex drive	0 1 2 3	Nervous/anxious	0 1 2 3
Ankle, foot or low back pain	0 1 2 3	Cry easily	0 1 2 3

THYROID FUNCTION

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Tires, sluggish, fatigue	0 1 2 3	Cold hands, feet, body	0 1 2 3
Trouble waking in morning	0 1 2 3	Weight gain even with low cal diet	0 1 2 3
Difficulty losing weight	0 1 2 3	Constipation, infrequent BMs	0 1 2 3
Depression, lack of motivation	0 1 2 3	Morning headache that wears off	0 1 2 3
Thinning hair on outer eyebrow	0 1 2 3	Hair loss or thinning on scalp	0 1 2 3
Dry skin and scalp	0 1 2 3	Mental sluggishness	0 1 2 3
Ringing in ears or noises in head	0 1 2 3	Nervous, emotional, anxious	0 1 2 3
Fast pulse even at rest	0 1 2 3	Night sweats	0 1 2 3
Insomnia	0 1 2 3	Intolerant of high temperatures	0 1 2 3
Difficulty gaining weight	0 1 2 3		

FEMALE REPRODUCTION HEALTH & HISTORY

Describe your menstrual cycle: Light/ or heavy _____
How many days _____
Cramping _____
Clotting _____
PMS _____
What do you use to relieve these symptoms? _____Does it help? _____

Are you sexually active?_____ If so, what method of birth control do you use? _____

List types of birth control used in the past: _____

Used for how long? _____ _____

Used for how long? _____

How many times pregnant? _____ How many children? _____ Miscarriages? _____

Type of delivery: vaginal _____ caesarean _____

Menopausal ?_____ Since what age? _____ Use of replacement hormones? _____

Pain with intercourse	0 1 2 3	Vaginitis/abnormal discharge	0 1 2 3

Abnormal pap smear	0 1 2 3	Abnormal mammogram	0 1 2 3
Endometriosis	0 1 2 3	PCOS	0 1 2 3
Breast cysts	0 1 2 3	Fibroids	0 1 2 3

MALE REPRODUCTION HEALTH & HISTORY

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Hernia	0 1 2 3	Prostate inflammation/BPH	0 1 2 3
Erectile dysfunction	0 1 2 3	Difficulty urinating	0 1 2 3

EMOTIONAL HEALTH & HISTORY

Rank: 0 – least/ never; 1 – mild/ sometimes; 2 – moderate/ often; 3 – severe/almost always:

Depression	0 1 2 3	Anger	0 1 2 3
Anxiety, panic attacks	0 1 2 3	Irritability	0 1 2 3
Memory Loss	0 1 2 3	Brain fog	0 1 2 3
Difficulty concentrating	0 1 2 3	Hyperactivity	0 1 2 3
Impulsiveness	0 1 2 3	Feel overwhelmed	0 1 2 3

FAMILY HEALTH HISTORY

Has anyone in your family (including parents, grandparents, siblings, and children) experienced any of the following illnesses/ conditions?

Condition	Which family member	Condition	Which family member?
Heart Disease		Thyroid	
High blood pressure		Autoimmune issues	
Heart attack		Arthritis	
Stroke		Osteoporosis	
High cholesterol		Alzheimer's	
Diabetes		Dementia	
Asthma		Mental illness	
Cancer		Alcoholism	
Depression		Drug addiction	
Food allergies		Eating disorders	

DIET AND EATING HABITS

How many meals per day do you eat? _____

Do you follow any specific food guidelines (ie: vegan, vegetarian, gluten-free, Paleo, etc.)? _____

_____

3 Day Diet Journal (please include **everything** that goes in your mouth, give approximate amounts and brands/restaurants)

	Breakfast	Lunch	Dinner	Snack/beverages
Day 1				
Day 2				
Day 3				

What are some of your favorite foods? _____

What are some of your least favorite foods? _____

Which foods do you crave? _____

Do you crave sweets? _____ How often? _____When? _____

Do you consider yourself a fast or slow eater? _____

What do you drink during the day? _____

How many glasses (or ounces) of water each day? _____

How much alcohol do you consume during an average week? (# of beers/ glasses of wine or cocktails)
_____

Do you drink coffee? _____ How many cups per day? _____

Do you drink soda? _____ How many per day/ per week?_____

How often do you cook at home? _____

Do you like to cook? _____

How often do you eat at restaurants or take-out per week? _____
Which places do you frequent?
_____

How often do you grocery shop? _____Once a week _____Twice a week _____More frequently

Where do you usually eat? (ex: at table, in front of TV, at desk at work)_____

What is your idea of a healthy meal? _____

What does an unhealthy meal, one that doesn't make you feel good, look like?

_____

POTENTIAL TOXIN EXPOSURE

Have you been exposed to any toxins that you're aware of? _____
Have you ever lived near a manufacturing plant, farm or industrial area? _____
Have you ever worked on a farm or in a manufacturing plant? _____
Do you have (or did you have) mercury (silver) fillings in your teeth? _____
Did you grow up in a house built before 1976 that may have had lead paint? _____
Do you use solvents or paints in your work or hobbies? _____
Does your home have new carpet, new paint or new furniture? _____
Do you sleep on a new mattress? _____
Do you live in a brand new home? _____What year was it built? _____
Do you have a strong reaction to smells? _____
Are you very sensitive to medications and/ or caffeine? _____
Do you use pesticides, herbicides or cleaning chemicals in your house? _____
Do you travel often or have you worked in the airline industry? _____
Do you swim in a chlorinated pool often? _____
Do you drink well, tap, filtered or spring/ bottled water? _____
Did you receive all scheduled vaccinations as a child?_____
Have you recently received any vaccinations (for international travel or flu shot, etc.)?_____
Do you use nicotine? _____If so, what type? _____
Have you used nicotine in the past? _____What type?_____ For how long?_____
Are you often exposed to second hand smoke? _____
Do you use any recreational drugs? ____What types? _____How often? _____
Did you have a habit of using drugs in the past? If so, which ones? _____

LIFESTYLE & MOVEMENT

What is your stress level from 1 – 10 (1 being the lowest, 10 being the highest) _____

List your stressors: _____

How do you manage it? _____

Have you experienced a major stress in the past, such as divorce, loss of a loved one or pet, care taking an ill family member or friend, difficult relationship, etc.?
_____

_____
How many hours per night do you sleep? _____Do you wake up feeling refreshed?_____

Do you fall asleep easily? _____ Do you wake up in the night? _____

Do you frequently have insomnia? _____How many nights per week? _____

Are you tired throughout the day? _____ When? _____

How often do you exercise per week? _____ For how many minutes? _____

What type(s) of exercise? _____

Do you enjoy exercising? _____ Do you feel like you're in good shape? _____

What are your hobbies and past times? _____

Are you happy with your life? _____

If not, what would you change? _____

What challenges do you face in order to create that happiness? _____

On a scale of 1 – 10 (10 being the highest) how committed are you to your goals? _____

On a scale of 1 – 10 (10 being the highest) how willing are you to change your diet and eating habits?
_____

What else would you like to share?
_____

_____

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