TRANSCEND HEALTH & NUTRITION

LIFESTYLE INTAKE FORM

PERSONAL INFORMATION

First Name: Last Name:

Address: City: State ZIP:

Email:

Phone: Home Mobile

DOB: Height: Current weight: Goal weight:

Primary Physician and Phone:

SOCIAL INFORMATION

Occupation: Hours of work per week:

MEDICAL & HEALTH INFORMATION

Do you have any known food allergies, intolerances, or sensitivities?

Do you or have you ever had an eating disorder? i.e. anorexia, bulimia, pica, rumination disorder, binge eating disorder, body image distortion, avoidance/restrictive food intake disorder? If yes, please explain so we can better assist you.

How do you sleep? How many hours? Do you wake up at night? ☐ Yes ☐ No

Do you have: ☐ Constipation ☐ Diarrhea ☐ Gas ☐ Bloating ☐ Digestive issues?

Do you suffer from fatigue? ☐ Always ☐ Sometimes ☐ Never

Do you smoke? ☐ Yes How much? ☐ No

Do you drink alcohol? ☐ Yes How frequently and how much? ☐ No

FAMILY HISTORY

Please note any family history of the following diseases: heart disease, cancer, stroke, high blood pressure, overweight, lung disease, kidney disease, diabetes, mental illness or addiction, etc.

Family Member: Health Condition:

Family Member: Health Condition:

Family Member: Health Condition:

Known Genetic Disorders:

Comments:

MEDICAL HISTORY

Please check health conditions that your doctor has diagnosed and provide the date of onset

Gastrointestinal	Now	Past
Celiac Disease	☐	☐
Crohn's Disease	☐	☐
Gastric or Peptic Ulcer Disease	☐	☐
GERD/heartburn/reflux	☐	☐
Irritable Bowel Syndrome	☐	☐
Liver Disease	☐	☐
Small Intestinal Bacterial Overgrowth	☐	☐
Ulcerative Colitis	☐	☐
Other:	☐	☐

Respiratory	Now	Past
Asthma	☐	☐
Bronchitis	☐	☐
Chronic Sinusitis	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Sleep Apnea	☐	☐
Tuberculosis	☐	☐
Other:	☐	☐

Cardiovascular	Now	Past
Atherosclerosis	☐	☐
Elevated cholesterol	☐	☐
Heart attack	☐	☐
High blood pressure	☐	☐
Irregular heart beat	☐	☐
Mitral Valve Prolapse	☐	☐
Other:	☐	☐

Neurological/Brain	Now	Past
ADD/ADHD	☐	☐
Alzheimer's disease	☐	☐
Anorexia	☐	☐
Anxiety	☐	☐
Asperger's	☐	☐
Autism	☐	☐
Bulimia	☐	☐
Eating disorder, Unspecified	☐	☐
Memory problems	☐	☐
Parkinson's disease	☐	☐
Seizures	☐	☐
Stroke	☐	☐
Other:	☐	☐

Inflammatory / Autoimmune	Now	Past
Chronic Fatigue Syndrome	☐	☐
Epstein-Barr Virus	☐	☐
Graves' Disease	☐	☐
Gout	☐	☐
Hashimoto's thyroiditis	☐	☐
Herpes	☐	☐
Lupus SLE	☐	☐
Poor Immune Function (frequent infections)	☐	☐
Rheumatoid Arthritis	☐	☐
Other:	☐	☐

Musculoskeletal / Pain	Now	Past
Chronic Pain	☐	☐
Fibromyalgia	☐	☐
Migraines	☐	☐
Osteoarthritis	☐	☐
Other:	☐	☐

Cancer	Now	Past
	☐	☐
	☐	☐

Metabolic / Endocrine	Now	Past
Diabetes: Type 1 ☐ Type 2 ☐	☐	☐
Hypoglycemia	☐	☐
Hypothyroidism (low thyroid)	☐	☐
Hyperthyroidism (over active thyroid	☐	☐
Infertility	☐	☐
Metabolic Syndrome (pre-diabetes, insulin resistance)	☐	☐
Polycystic Ovarian Syndrome (PCOS)	☐	☐
Other:	☐	☐

Acne	☐	☐
Eczema	☐	☐
Psoriasis	☐	☐
Rosacea	☐	☐
Skin Rash	☐	☐
Other:	☐	☐

Urinary / Gynecological (men/women)	Now	Past
Kidney Stones	☐	☐
Prostate problems	☐	☐
Urinary tract infection (UTI)	☐	☐
Yeast overgrowth/infection	☐	☐
Other:	☐	☐

MEDICATIONS, SUPPLEMENTS AND VITAMINS

List all prescription medications and dietary supplements (vitamins, minerals, herbs/botanicals) you are currently taking.

Medication name	Dose	Frequency	Reason

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged use or regular use of opioid pain killers? ☐ Yes ☐ No

Have you had prolonged or regular use of PPI's or acid-blocking drugs (Prilosec, Nexium, Prevacid)? ☐ Yes ☐ No

Frequent antibiotics >3 times per year? ☐ Yes ☐ No Long term antibiotics? ☐ Yes ☐ No

Have you had prolong or regular use of any type of psychiatric medication? ☐ Yes ☐ No

Do you currently use any of the following (i.e. marijuana, cocaine, crack, heroin, speed, etc.)? ☐ Yes ☐ No

If yes, please describe the type of substance(s)? How often do you use them?

NUTRITION HISTORY

Have you ever had a nutrition consultation? ☐ Yes ☐ No

If yes, date & describe outcome:

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

Please describe:

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Please describe:

Do you avoid any particular foods or beverages? ☐ Yes ☐ No

If yes, what do you avoid and explain why?

What % of meals do you eat out per week? ☐ >75% ☐ 50-75% ☐ 25-50% ☐ < 25%

Meal most often eaten out: ☐ Breakfast ☐ Lunch ☐ Dinner

Are there special textures you prefer? Or avoid certain textures for a particular reason? Please describe:

What is your average daily water consumption (8-ounce glass)? ☐ 6-8 ☐ 4-6 ☐ 2-4 ☐ <2

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

- ☐ Fast eater
- ☐ Love to eat
- ☐ Struggle with eating issues
- ☐ Erratic eating patterns
- ☐ Love to cook
- ☐ Emotional eating
- ☐ Eat too much/overeat
- ☐ Eat fast food frequently
- ☐ Late night eating
- ☐ Live or often eat alone
- ☐ Poor snack choices
- ☐ Rely on convenience items
- ☐ Time constraints
- ☐ Do not plan meals or menus
- ☐ Associate symptoms with eating
- ☐ Drink too much alcohol
- ☐ Travel frequently
- ☐ Negative relationship with food
- ☐ Addicted to sugar/sweets
- ☐ Confused about nutrition advice
- ☐ Dislike healthy food
- ☐ Eat too many processed carbs (breads, pastas, chips, etc.)
- ☐ Organic food is important to me

Please note any additional comments about your eating habits:

PERSONAL WEIGHT HISTORY

Describe your weight during different milestones of your life. During what periods of your life did you gain and lose weight?

Weight History	Toddler	Elementary Years	High School	20's-30's	Pregnancy	30's-40's	40-50's	50+
Gain	☐	☐	☐	☐	☐	☐	☐	☐
Loss	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

What weight loss programs, types of diets, medications/supplements, have you previously tried? What were your likes and dislikes for each?

Type of Diet & Year	Likes	Dislikes

What are your weight loss goals?

What are your motivations to reach these goals?

PHYSICAL ACTIVITY INFORMATION

Please choose a statement below that best describes your current physical activity level. Please use the physical activity goal for adults listed below.

☐ I am not currently doing any physical activity and I do not intend on becoming physically active
☐ I am not currently doing any physical activity, but I intend on becoming more physically active soon.
☐ I am doing some physical activity, but I am not doing the amount described above
☐ I am currently meeting the physical activity guideline stated above, but I have been doing it for less than 6 months
☐ I am currently meeting the physical activity guideline stated above, but I have been doing it for more than 6 months

Weekly Physical Activity Goal for Adults

- 150 minutes of moderate-intensity physical activity (i.e. brisk walking, playing Frisbee, general gardening)
- 75 minutes of vigorous-intensity activity (i.e .jogging, aerobic dancing)
- Combination of moderate & vigorous exercise
- Muscle-strengthening exercises two or more days per week (i.e. using weights or body resistance)

Please fill in your activity level via chart:

Type of Physical Activity	Example: Walking					
Number of days/ weeks	3					
Minutes per day	15					
Total minutes per week	45					
Intensity	Moderate					

NUTRITION INFORMATION

How many meals do you eat daily?

Do you snack often? ☐ Yes ☐ No What do you eat for snacks?

Describe what you eat on a typical day?

Do you use artificial sweeteners? ☐ Yes ☐ No

Please describe your liquid consumption:

Do you cook? ☐ Yes ☐ No

Do you have any food addictions? ☐ Yes ☐ No Please describe

When do your cravings occur most often?

- ☑ After meals
- ☐ Mid-day
- ☐ Evening (after supper)
- ☐ Late at night

When eating a meal, I am...

- ☐ Sitting with others/sitting alone
- ☐ Standing
- ☐ On the go/in my vehicle/working at my desk
- ☐ In front of the computer, on the phone, TV, or other media device

When eating a meal, I tend to:

- ☐ Chew my food thoroughly and eat slowly
- ☐ Sometimes chew well
- ☐ Eat as fast as I can with little to no chewing

EMOTIONAL HISTORY

Daily Stressors: Rate on a scale of 1 (low) to 10 (high)

☐ Work ☐ Family ☐ Social ☐ Finances ☐ Health ☐ Other

How do you handle stress, what relaxes you?

Excess stress in your life? ☐ Yes ☐ No History of trauma? ☐ Yes ☐ No

Do you feel your life has meaning and purpose? ☐ Yes ☐ No ☐ Unsure

Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No

Average number of hours you sleep per night during the week? ☐ <6 ☐ 6-8 ☐ 8-10 ☐ 10+

Average number of hours you sleep per night on weekends? ☐ <6 ☐ 6-8 ☐ 8-10 ☐ 10

Trouble falling asleep? ☐ Yes ☐ No Rested upon waking? ☐ Yes ☐ No

Do you wake up during the night? ☐ Yes ☐ No If yes, how many times?

How would you rate the overall quality of your sleep? ☐ 1 Low ☐ 2 ☐ 3 ☐ 4 ☐ 5 High

Will family and/or friends be supportive of your desire to make lifestyle changes? ☐ Yes ☐ No

ENVIRONMENTAL HISTORY

Do you experience or have you been diagnosed with chemical sensitivities? ☐ Yes ☐ No

If yes, please describe:

Are you exposed regularly to any of the following? Check all that apply:

- ☐ Aluminum cookware
- ☐ Auto exhaust/fumes
- ☐ Chemicals
- ☐ Cosmetics: nail polish / hair dyes/perfumes
- ☐ Dry-cleaned clothes
- ☐ Fertilizers
- ☐ Heavy metals
- ☐ Pesticides
- ☐ Pet dander
- ☐ Mold
- ☐ Other
- ☐ Cigarette smoke
- ☐ Paint fumes

Please describe any significant past exposure to harmful chemicals/substances.

READINESS ASSESSMENT

What do you think would make the most difference in your overall health?

In order to improve your health, how willing are you to:	Rate on a scale of 5 (very willing) to 1 (not willing)				
Significantly modify your diet	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Modify your lifestyle (e.g., work demands, sleep habits, exercise)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Engage in regular exercise/physical activity	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Practice a daily relaxation technique	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Take nutritional supplements as recommended	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Have periodic lab / Bio-energetic testing to assess your progress	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Comments:

DIGESTIVE HISTORY

DIRECTIONS: This questionnaire asks you to assess how you have been feeling during the last four months. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

0 = No or Rarely-You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant. (monthly or less)

1 = Occasionally-Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = ften-Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently-Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Section A	No/Rarely	Occasionally	Often	Frequently
1. Indigestion, food repeats on you after you eat	☐ 0	☐ 1	☐ 4	☐ 8
2. Excessive burping, belching and/or bloating following meals	☐ 0	☐ 1	☐ 4	☐ 8
3. Stomach spasms and cramping during or after eating	☐ 0	☐ 1	☐ 4	☐ 8
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	☐ 0	☐ 1	☐ 4	☐ 8
5. Bad taste in your mouth	☐ 0	☐ 1	☐ 4	☐ 8
6. Small amounts of food fill you up immediately	☐ 0	☐ 1	☐ 4	☐ 8
7. Skip meals or eat erratically because you have no appetite.	☐ 0	☐ 1	☐ 4	☐ 8
TOTAL POINTS	____	_____	_____	_____

Section B	No/Rarely	Occasionally	Often	Frequently
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	☐ 0	☐ 1	☐ 4	☐ 8
2. Feel hungry an hour or two after eating a good- sized meal	☐ 0	☐ 1	☐ 4	☐ 8
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	☐ 0	☐ 1	☐ 4	☐ 8
4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids	☐ 0	☐ 1	☐ 4	☐ 8
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	☐ 0	☐ 1	☐ 4	☐ 8
6. Digestive problems that subside with rest and relaxation	☐ NO			☐ YES
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	☐ 0	☐ 1	☐ 4	☐ 8
8. Feel a sense of nausea when you eat	☐ 0	☐ 1	☐ 4	☐ 8
9. Difficulty or pain when swallowing food or beverage	☐ 0	☐ 1	☐ 4	☐ 8
TOTAL POINTS	____	_____	_____	_____

Section C	No/Rarely	Occasionally	Often	Frequently
1. When massaging under your rib cage on your left side, there is pain, tenderness or soreness	☐ 0	☐ 1	☐ 4	☐ 8
2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	☐ 0	☐ 1	☐ 4	☐ 8
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	☐ 0	☐ 1	☐ 4	☐ 8
4. Specific foods/beverages aggravate indigestion				
5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day	☐ 0	☐ 1	☐ 4	☐ 8
6. Stool odor is embarrassing	☐ 0	☐ 1	☐ 4	☐ 8
7. Undigested food in your stool	☐ 0	☐ 1	☐ 4	☐ 8
8. Three or more large bowel movements daily	☐ 0	☐ 1	☐ 4	☐ 8
9. Diarrhea (frequent loose, watery stool	☐ 0	☐ 1	☐ 4	☐ 8
10. Bowel movement shortly after eating (within 1 hr)	☐ 0	☐ 1	☐ 4	☐ 8
TOTAL POINTS	____	_____	_____	_____

Section D	No/Rarely	Occasionally	Often	Frequently
1. Discomfort, pain or cramps in your colon (lower abdominal area)	☐ 0	☐ 1	☐ 4	☐ 8
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	☐ 0	☐ 1	☐ 4	☐ 8
3. Generally constipated (or straining during bowel movements)	☐ 0	☐ 1	☐ 4	☐ 8
4. Stool is small, hard and dry	☐	☐	☐	☐
5. Pass mucus in your stool	☐ 0	☐ 1	☐ 4	☐ 8
6. Alternate between constipation and diarrhea	☐ 0	☐ 1	☐ 4	☐ 8
7. Rectal pain, itching or cramping	☐ 0	☐ 1	☐ 4	☐ 8
8. No urge to have a bowel movement	☐ 0	☐ 1	☐ 4	☐ 8
9.An almost continual need to have a bowel movement	☐ 0	☐ 1	☐ 4	☐ 8
TOTAL POINTS	_____	_____	_____	_____

Digestive History Key:
0-15 - mild GI issues 16-50 - moderate GI issues >51 - significant GI issues

GOALS & CONCERNS

What do you hope to achieve in your visit?

How would you rate your current health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

List your three main health/nutrition concerns:

1.

2.

3.

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

PATIENT NARRATIVE

Please write a summary of any information that will be helpful to me regarding your health and medical history or in your own words, tell me your story