**GENERAL INFORMATION**

**Name** First Middle Last

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender ☐ Male ☐ Female

**Genetic Background**

☐ African ☐ European ☐ Native American ☐ Mediterranean ☐ Asian ☐ Ashkenazi ☐ Middle Eastern Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Job Title**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nature of Business\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Address Number** Street City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone**

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred by**

☐ Book ☐ Website ☐ Media ☐ Family or Friend ☐PCP ☐ CC Physician ☐ other

**ALLERGIES**

|  |  |
| --- | --- |
| Medication / Supplement / Food  | Reactions  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**COMPLAINTS/ CONCERNS**

What do you hope to achieve in your visit with us?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you had a magic wand and could erase three problems, what would they be? 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does feeling well mean to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your motivations to your change in health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes you feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes you feel better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list current and ongoing problems in order of priority:**

|  |  |  |  |
| --- | --- | --- | --- |
| Describe problem Ex: Post nasal Drip | OnsetJune 20017 | Frequency 4 times/week | Severity Mild/Moderate/Severe |
|  |  |  |  |
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**Disease / Conditions- In front of each condition write down the date of onset. (Mark the first box if this condition has happened in the past and second box if it ongoing)**

**GASTROINTESTINAL Condition** **GENITAL AND URINARY SYSTEM**

☐ ☐ Irritable Bowel Syndrome\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Kidney Stones\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Inflammatory Bowel Disease\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Gout\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Crohn’s\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Interstitial Cystitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Ulcerative Colitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Frequent Urinary Tract Infections\_\_\_\_\_\_\_\_

☐ ☐ Gastritis or Peptic Ulcer Disease\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Frequent Yeast Infection\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ GERD (reflux)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Erectile Dysfunction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐☐ ☐ Celiac Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Sexual Dysfunction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARDIOVASCULAR**  **MUSCULOSKELETAL/PAIN**

☐ ☐ Heart Attack\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Osteoarthritis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Other Heart Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Fibromyalgia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Chronic Pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Elevated Cholesterol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Other

☐ ☐ Arrhythmia (irregular heart rate)\_\_\_\_\_\_\_\_\_\_\_ **INFLAMMATORY/AUTOIMMUNE**

☐ ☐ Hypertension (high blood pressure)\_\_\_\_\_\_\_\_\_ ☐ ☐ Chronic Fatigue Syndrome\_\_\_\_\_\_

☐ ☐ Rheumatic Fever\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Autoimmune Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Mitral Valve Prolapse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Rheumatoid Arthritis\_\_\_\_\_\_

☐ ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Lupus SLE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **METABOLIC/ENDOCRINE** ☐ ☐ Immune Deficiency Disease\_\_\_\_\_\_\_\_

☐ ☐ Type 1 Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Herpes-Genital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Type 2 Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Severe Infectious Disease\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Hypoglycemia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Poor Immune Function\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Metabolic Syndrome\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (frequent infections)

(Insulin Resistance or Pre-Diabetes) ☐ ☐ Food Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ☐ ☐ Hypothyroidism (low thyroid)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Environmental Allergies\_\_\_\_\_\_\_\_\_

☐ ☐ Hyperthyroidism (overactive thyroid)\_\_\_\_\_\_\_\_ ☐ ☐ Multiple Chemical Sensitivities\_\_\_\_\_\_\_\_

☐ ☐ Endocrine Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Latex Allergy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Polycystic Ovarian Syndrome (POCS)\_\_\_\_\_\_\_ ☐ ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Infertility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **RESPIRATORY DISEASES**

☐ ☐ Weight Gain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Asthma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Weight Loss\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Chronic Sinusitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Frequent Weight Fluctuations\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Bronchitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Bulimia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Emphysema\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Anorexia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Pneumonia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Binge Eating Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Tuberculosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Night Eating Syndrome\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Sleep Apnea\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Eating Disorder (non-specific)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **CANCER SKIN DISEASES**

☐ ☐ Lung Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Eczema\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Breast Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Psoriasis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Colon Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Acne\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Ovarian Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Melanoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Prostate Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Skin Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Skin Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NEUROLOGICAL**

☐ ☐ Depression\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Mild Cognitive Impairment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Anxiety\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Memory Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Bipolar Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Parkinson’s Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ ☐ Schizophrenia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Multiple Sclerosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Headaches\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ ALS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Migraines\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Seizures\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ ADD/ADHD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Other Neurological Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐ Autism\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVENTIVE TESTS SURGERIES**

Check the box if yes & provide date of onset ☐Appendectomy\_\_\_\_\_\_\_\_\_\_\_

☐ Full Physical Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Hysterectomy +/- Ovaries\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Bone Density\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Gall Bladder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Colonoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Hernia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Cardiac Stress Test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Tonsillectomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ EBT Heart Scan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Dental Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ EKG\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Joint Replacement – Knee/Hip\_\_\_\_\_\_\_\_\_\_\_\_

☐ Hemoccult Test-stool test for blood\_\_\_\_\_\_\_\_\_ ☐ Heart Surgery - Bypass Valve\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ MRI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Angioplasty or Stent\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ CT Scan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Pacemaker\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Upper Endoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Upper GI Series\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ None

☐ Ultrasound\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INJURIES**  **BLOOD TYPE:**

☐ Back Injury ☐ A ☐ B ☐ AB ☐ O ☐ Rh+ ☐ Unknown

☐ Head Injury

☐ Neck Injury

☐ Broken Bones

☐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GYNECOLOGIC HISTORY** (for women only) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OBSTETRIC HISTORY Check box if yes and provide number of

☐ Pregnancies\_\_\_\_\_\_\_\_\_\_\_ ☐ Caesarean\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Vaginal Deliveries\_\_\_\_\_\_\_\_\_\_\_\_

☐ Miscarriage\_\_\_\_\_\_\_\_\_\_\_ ☐ Abortion\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Living Children\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Post-Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby Over 8 Pounds

☐ Breast Feeding for how long? \_\_\_\_\_\_\_\_\_\_\_\_

**MENSTRUAL HISTORY**

Age at First Period: \_\_\_\_\_\_ Menses Frequency: \_\_\_\_\_ Length: \_\_\_\_\_ Pain: ☐Yes ☐No

Clotting: ☐Yes ☐No

Has your period ever skipped? \_\_\_\_\_ For how long \_\_\_\_\_\_\_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring

How long? \_\_\_\_\_\_\_\_\_\_\_\_

Do you use contraception? ☐Yes ☐No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

**WOMEN’S DISORDERS/HORMONAL IMBALANCES**

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Painful Periods ☐ Heavy Periods

☐ PMS Last Mammogram:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Breast Biopsy/Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Pap test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Normal ☐ Abnormal

Last Bone Density: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: ☐High ☐Low ☐Within Normal Range Are you in Menopause? ☐Yes ☐No Age at Menopause: \_\_\_\_\_\_\_\_\_\_\_\_ ☐Hot Flashes ☐Mood Swings

☐Concentration/Memory Problems ☐Vaginal Dryness ☐Decreased Libido ☐Heavy Bleeding

☐Joint Pains ☐Headaches ☐Weight Gain ☐Loss of Control of Urine ☐Palpitations ☐Use of hormone replacement therapy

How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEN’S HISTORY (for men only)**

Have you had a PSA done? ☐Yes ☐No

PSA Level: ☐0-2 ☐2-4 ☐4-10 ☐> 10

☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

☐ Nocturia (urination at night). How many times at night? \_\_\_\_\_\_\_\_\_\_\_\_

☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

**Current medications:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Dose | Frequency  | Start date  | Reason for taking  |
|  |  |  |  |  |
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**NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Supplement  | Dose | Frequency  | Start date  | Reason for taking  |
|  |  |  |  |  |
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Have your medications or supplements ever caused you unusual side effects or problems? ☐Yes ☐ No Describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.)

 ☐Yes ☐ No

Frequent antibiotics ☐Yes ☐ No

Long term antibiotics ☐Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ☐Yes ☐ No

Use of oral contraceptives ☐Yes ☐ No

**SOCIAL HISTORY**

NUTRITION HISTORY

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

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

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

Check all that apply: ☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic

☐ No Dairy ☐ No Wheat ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Ultrametabolism ☐ Specific Program for Weight Loss/Maintenance Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height (feet/inches)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Usual Weight Range +/- 5 lbs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Desired Weight Range +/- 5 lbs\_\_\_\_\_\_\_\_\_\_\_\_ Highest Adult Weight\_\_\_\_\_\_\_\_\_\_\_\_\_ Lowest Adult Weight\_\_\_\_\_\_\_\_\_

Weight Fluctuations (>10 lbs) ☐Yes ☐ No

Body Fat %\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Have you ever had your metabolism (resting metabolic rate) checked? ☐Yes ☐ No

If yes, what was it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you avoid any particular foods? ☐Yes ☐ No

If yes, types and reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If you could only eat a few foods a week, what would they be?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you grocery shop? ☐Yes ☐ No

 If no, who does the shopping?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you read food labels? ☐Yes ☐ No

Do you cook? ☐Yes ☐ No

 If no, who does the cooking?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many meals to you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ > 5 meals per week

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

☐ Fast eater ☐ Do not plan meals or menus

☐ Significant other or family members have special ☐ Eat too little under stress

☐ Erratic eating pattern dietary needs or food preferences ☐ Reliance on convenience items

☐ Eat too much ☐ don’t care to cook

☐ Love to eat ☐ Poor snack choices

☐ Late night eating ☐ Eating in the middle of the night

☐ Eat because I have to ☐ Confused about nutrition advice

☐ Dislike healthy food ☐ Emotional eater

☐ Time constraints

☐ Have a negative relationship to food

☐ Travel frequently bored)

☐ Non-availability of healthy foods

☐ Eat too much under stress

The most important thing I should change about my diet to improve my health is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SMOKING**

Currently Smoking? ☐Yes ☐ No If yes, how many years? \_\_\_\_\_\_\_\_\_ Packs per day:\_\_\_\_\_\_\_\_\_

Attempts to quit: \_\_\_\_\_\_\_\_\_\_\_\_

Previous Smoking: How many years? \_\_\_\_\_\_\_\_\_\_\_\_ Packs per day: \_\_\_\_\_\_\_\_\_\_\_\_

Second Hand Smoke Exposure?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALCOHOL INTAKE**

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits ☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10 If none, skip to “Other Substances” Previous alcohol intake? ☐ Yes (☐ Mild ☐ Moderate ☐High) ☐ None

Have you ever been told you should cut down your alcohol intake? ☐Yes ☐ No

 Do you get annoyed when people ask you about your drinking? ☐Yes ☐ No

Do you ever feel guilty about your alcohol consumption? ☐Yes ☐ No

Do you ever take an eye-opener? ☐Yes ☐ No

Do you notice a tolerance to alcohol (can you ”hold” more than others)? ☐Yes ☐ No

Have you ever been unable to remember what you did during a drinking episode? ☐Yes ☐ No

Do you get into arguments or physical fights when you have been drinking? ☐Yes ☐ No

Have you ever thought about getting help to control or stop your drinking? ☐Yes ☐ No

**OTHER SUBSTANCES**

Caffeine Intake: ☐Yes ☐ No | Coffee cups/day: ☐ 1 ☐ 2-4 ☐ > 4 | Tea cups/day: ☐ 1 ☐ 2-4 ☐ > 4 Caffeinated Sodas or Diet Sodas Intake: ☐Yes ☐ No 12-ounce can/bottle: ☐ 1 ☐ 2-4 ☐ > 4

List favorite type (Ex. Diet Coke, Pepsi, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently using any recreational drugs? ☐Yes ☐ No If yes, type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used IV or inhaled recreational drugs? ☐Yes ☐ No

**EXERCISE**

Current Exercise Program: (List type of activity, number of sessions/week, and duration)

|  |  |  |  |
| --- | --- | --- | --- |
| Activity  | Type | Frequency per week | Duration in minutes  |
|  |  |  |  |
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Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High List problems that limit activity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you feel unusually fatigued after exercise? ☐Yes ☐ No If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you usually sweat when exercising? ☐Yes ☐ No

**PSYCHOSOCIAL**

Do you feel significantly less vital than you did a year ago? ☐Yes ☐ No

Are you happy? ☐Yes ☐ No

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

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

Do you like the work you do? ☐Yes ☐ No

Have you ever experienced major losses in your life? ☐Yes ☐ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations?

☐Yes ☐ No

Would you describe your experience as a child in your family as happy and secure? ☐Yes ☐ No **STRESS/COPING**

Have you ever sought counseling? ☐Yes ☐ No

Are you currently in therapy? ☐Yes ☐ No Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you have an excessive amount of stress in your life? ☐Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐Yes ☐ No

Daily Stressors: Rate on scale of 1-10 Work\_\_\_\_\_ Family\_\_\_\_\_ Social\_\_\_\_\_ Finances\_\_\_\_\_ Health\_\_\_\_\_ Other\_\_\_\_\_

Do you practice meditation or relaxation techniques? ☐Yes ☐ No

How often?\_\_\_\_\_\_\_\_\_\_\_\_

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐Yes ☐ No SLEEP/REST Average number of hours you sleep per night: ☐ > 10 ☐ 8-10 ☐ 6-8 ☐ < 6

Do you have trouble falling asleep? ☐Yes ☐ No

Do you feel rested upon awakening? ☐Yes ☐ No

Do you have problems with insomnia? ☐Yes ☐ No

Do you snore? ☐Yes ☐ No

Do you use sleeping aids? ☐Yes ☐ No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ROLES/RELATIONSHIP**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long term partnership ☐ Widow List Children: Who is Living in Household?\_\_\_\_\_\_\_\_\_\_\_ Number:\_\_\_\_\_\_\_\_

Resources for emotional support? Check all that apply:

☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your sex life? ☐Yes ☐ No

How well have things been going for you?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Overall | Very Well | Fine | Poor | N/A |
| At School |  |  |  |  |
| In your job |  |  |  |  |
| In your social life  |  |  |  |  |
| With close friends  |  |  |  |  |
| With your attitude |  |  |  |  |
| Relationship  |  |  |  |  |
| Children  |  |  |  |  |
| Parents  |  |  |  |  |
| Your significant other  |  |  |  |  |
| With yourself  |  |  |  |  |

**READINESS ASSESSMENT**

Rate on a scale of 5 (very willing) to 1 (not willing):

 In order to improve your health, how willing are you to:

Significantly modify your diet……………………………………….☐5 ☐4 ☐3 ☐2 ☐1

Take several nutrition supplements each day…………………………☐5 ☐4 ☐3 ☐2 ☐1

Keep a record of everything you eat each day……………………… ☐5 ☐4 ☐3 ☐2 ☐1

Modify your lifestyle (e.g., work demands, sleep habits)……………☐5 ☐4 ☐3 ☐2 ☐1

Practice a relaxation technique……………………………………….☐5 ☐4 ☐3 ☐2 ☐1

Engage in regular exercise……………………………………………☐5 ☐4 ☐3 ☐2 ☐1

Have periodic lab tests to assess your progress………………………☐5 ☐4 ☐3 ☐2 ☐1 Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Rate on a scale of 5 (very confident) to 1 (not confident at all): How confident are your of your ability to organize and follow through on the above health related activities? ☐5 ☐4 ☐3 ☐2 ☐1

 If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate on a scale of 5 (very supportive) to 1 (very unsupportive): At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

☐5 ☐4 ☐3 ☐2 ☐1

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact): How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐5 ☐4 ☐3 ☐2 ☐1 Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3-DAY DIET DIARY INSTRUCTIONS**

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

• Describe the food or beverage as accurately as possible e.g., milk- what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ and ½).

• Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.

 • Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.

 • Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.

 • Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc.). • Please note all bowel movements and their consistency (regular, loose, firm, etc.)

**DIET DIARY – DAY 1**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daily Exercise (Type of Activity / Time of Day / Duration): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daily Bowel Movements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Time  | Food/ beverage/snack  | Comments  |
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**DIET DIARY – DAY 2**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daily Exercise (Type of Activity / Time of Day / Duration): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daily Bowel Movements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Time  | Food/ beverage/snack  | Comments  |
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**DIET DIARY – DAY 3**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daily Exercise (Type of Activity / Time of Day / Duration): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daily Bowel Movements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| Time  | Food/ beverage/snack  | Comments  |
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Other comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_