DR. CRYSTAL RUSSAK, D.C **SUPERIOR CHIROPRACTIC**
4-570 Red River Rd., Thunder Bay, ON, P7B 1H3
Ph: (807)345-6700 Fax: (807)345-6717

Nutrition Consultation Intake Form Name: _____
Phone: _____

Health Concerns

1. What is your main purpose in coming here today?

_____
_____

2. What are your main health concerns/complaints?

_____
_____

3. Out of all of the concerns, which ones feel most urgent/important to you & why?

_____
_____

4. How have you dealt with these concerns in the past?

❑ Doctors

❑ Self-care

5. Have you experienced any success with these approaches? ❑Yes ❑No

6. What other health practitioners are you currently seeing? List name, specialty and phone # below:

_____

7. Please list the date and description of any surgical procedures you have had:

_____

8. How often did you take antibiotics in infancy/childhood? (rarely) 1 2 3 4 5 (frequently)

9. How often did you take antibiotics as a teen? (rarely) 1 2 3 4 5 (frequently)

10. How often have you taken antibiotics as an adult? (rarely) 1 2 3 4 5 (frequently)

11. List all prescription medications you are currently taking

_____

12. List all supplements you are currently taking

_____
_____

Nutritional Status

13. Have you ever seen a Nutritionist before? ❑Yes ❑No

14. List 3 things you liked about your previous experience with a Nutritionist

1. _____ 2._____ 3. _____

15. Are there any foods that you avoid because of the way they make you feel: If yes, please name the food and the symptom:

_____
_____

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16. Do you have symptoms immediately after eating like bloating, gas, diarrhea, cramping or hives: If so, please explain:

_____
_____

17. Are you aware of any delayed symptoms after eating like bloating, gas, diarrhea, headaches or hives: If so, please explain:

_____
_____

18. Are there any foods you crave?: If so, please explain:

_____
_____

19. Describe your diet at the onset of your health concerns:

_____
_____

20. Do you have any known allergies or sensitivities? If so, please list:

_____
_____

21. Which of the following foods do you consume regularly?
❑Soda ❑Diet Soda ❑Refined Sugar ❑Alcohol ❑Fast Food ❑Gluten (Wheat, Rye, Barley) ❑Dairy (Milk, Cheese, Yogurt) ❑Coffee

22. Are you currently on a special diet?
❑Ovo-Lacto ❑Diabetic ❑Dairy-Free ❑Vegetarian ❑Vegan ❑Paleo ❑Blood Type ❑Raw ❑Refined Sugar-Free ❑Gluten-Free ❑Other _____

23. What % of your meals are home-cooked?
❑10-20 ❑30-40 ❑50 ❑60-70 ❑80-90 ❑100

24. How often do you dine out? ❑Seldom ❑1 per week ❑2-3 per week ❑More than 3

25. Who does most of the grocery shopping, planning and cooking of meals in your house?

_____

26. Is there anything else I should know about your current diet, history or relationship to food? If yes, please explain:

_____
_____

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Intestinal Status

27. Bowl Movement Frequency: ❑1-3 times per day ❑more than 3 times per day ❑ not regularly every day
28. Bowel Movement Consistency: ❑soft & well formed ❑often float ❑difficult to pass ❑diarrhea ❑thin, long or narrow
❑small and hard ❑loose but not watery ❑alternating between hard and loose
29. Bowel Movement Colour: ❑medium brown ❑very dark or black ❑greenish❑ blood is visible❑variable ❑yellow, light
brown ❑chalky coloured ❑greasy, shiny
30. Do you experience intestinal gas: If so, please explain if it is excessive, occasional, odorous etc.

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31. Do you experience any of the following digestive system symptoms:
❑Heart Burn ❑Acid Reflux ❑Burping ❑Bloating

Health History

32. Do you experience any of the following symptoms:
❑Headaches ❑Migraines ❑Hot Flashes ❑Aches and Pains ❑Psoriasis ❑Eczema
❑Dry Skin ❑Cracking Nails ❑Brittle Hair ❑Cracking Skin ❑Congestion
33. Have you ever been diagnosed with any of the following conditions? If yes, briefly describe your symptoms, chosen
treatment(s) and dates:
❑Diabetes ❑High Cholesterol ❑High Blood Pressure ❑Depression ❑Osteoporosis
❑Heart Disease ❑Hepatitis ❑Kidney
Disease ❑Thyroid Disease ❑Cancer Type:_____ ❑Depression ❑
Asthma ❑Allergies ❑Anemia ❑
Chronic Yeast Infections ❑Other
Details:
_____
34. My Family History:
❑Alcoholism ❑Allergies ❑Arthritis ❑Asthma ❑Cancer ❑Diabetes ❑Dementia
❑Gall Bladder Problems ❑Heart Disease ❑Hypertension ❑Intestinal Disease
❑Kidney Disfunction ❑Osteoporosis ❑Ulcers
❑Other_____

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Health Hazards

35. Have you been exposed to any chemical or toxic metals (lead, mercury, arsenic, aluminum)? ❑Yes ❑No
36. Do You Smoke ❑Yes ❑No
37. Do odors affect you? ❑Yes ❑No
38. Are you or have you been exposed to any of the following: ❑second-hand smoke ❑mold ❑asbestos ❑strong cleaning chemicals (daily)
39. Do you have mercury amalgam fillings? ❑Yes ❑No

Lifestyle History

40. Have you had periods of eating junk food, binge eating or dieting? ❑Yes ❑No
List any known diet that you have been on for a significant amount of time (i.e. Weight Watchers, Dr Bernstein, Paleo, Isagenix, Juice Fasting, U Weight Loss)

_____
_____

41. Have you used or abused ❑alcohol, ❑drugs, ❑meds, ❑tobacco or ❑caffeine? If Do you still?
42. How stressed out are you on a regular basis? please circle (best) 1 2 3 4 5 (worst)
43. How do you handle stress? (Exercise, meditate, deep breathing etc)

_____
_____

44. How many hours on average do you sleep daily? _____
45. Do you sleep through the night on a regular basis? ❑Yes ❑No If no, why?

_____

46. Can you get to sleep easily? ❑Yes ❑No
47. Can you stay asleep? ❑Yes ❑No
48. What time do you go to sleep? _____ Awaken?

_____

49. Do you wake up feeling rested? ❑Yes ❑No
50. Have you or your family recently experienced any major life changes? If so, please comment:

_____
_____

51. How much time have you had to take off work or school in the last year? ❑0-2 days ❑3-14 days ❑more than 15 days

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Women Only

52. Are you or could you be pregnant? ❑Yes ❑No
53. How are (or were) your periods?

_____

54. Do or did you have PMS?

_____

55. Were your periods painful?

_____

56. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?
❑Yes ❑No
57. Are you pre-menopausal or menopausal? ❑Yes ❑No
58. Are you experiencing any menopausal symptoms? ❑Yes ❑No
If yes, please specify

_____

59. Have you had a bone density test? ❑Yes ❑No If yes, what was the result?

_____

60. Have you experienced any ❑yeast infections or ❑urinary tract infections? Are they regular? ❑Yes ❑No
61. Have you or do you still take birth control pills? If so, please list length of time and type:_____
62. Have you had any problems with conception or pregnancy? ❑Yes ❑No
63. Are you taking any hormone replacement therapy or hormonal supportive herbs: If so, please list again here

_____

_____

Mental Health Status

64. How are your moods in general? Do you experience more than you would like of ❑anxiety? ❑Depression? ❑Anger?
65. Describe your usual level of energy (worst) 1 2 3 4 5 6 7 8 9 10 (best)
66. At what point in your life did you feel best? Why?

_____

_____

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Other

67. When was the last time you participated in a regular exercise program?
_____
68. Who is included in your support system? ❑Spouse ❑Child ❑Parent ❑Sibling ❑ No One
69. Please describe any other information you think would be useful in helping to address your health concern(s)
_____
_____
_____
_____