Good Health Nutrition and Chiropractic Center
Nutritional Intake Form

Contact Information
Last Name: _____ First Name: _____ M.I._____

Preferred Name: _____ Gender:☐M ☐F DOB:_____ Age:_____

Address:_____

City: _____ State: _____ Zip: _____

Phone: *(home)* _____ *(cell)* _____ *(work)* _____

Is it okay to leave a voice message? ☐Home ☐Cell ☐Work ☐None
Email Address: _____ Is it okay to correspond with you by email? ☐Yes ☐No

Emergency Contact: _____ Phone: _____

Insurance
Do you have insurance? ☐Yes ☐No

Insurance Name: _____ Phone: _____
Policy/ID Number: _____ Group Number: _____
Secondary Insurance? ☐Yes ☐No
Insurance Name: _____ Phone: _____
Policy/ID Number_____ Group Number: _____

MEDICAL RELEASE: I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.
AUTHORIZATION OF PAYMENT: I authorize payment of medical benefits directly to Goodhealth Chiropractic I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am reponsible for any balance due.

Signature: _____ Date: _____

Healthcare Provider Information

Who is your primary care physician? Name: _____ Phone: _____
When was your last phyical exam? _____ Are you currently under the care of a specialist? ☐***Yes*** ☐***No***
Name: _____ Address/Phone _____

How would you describe most meals: ☐Relaxed ☐Rushed ☐Standing in front of TV
☐Seated at the table ☐In the car ☐Alone ☐With family and friends

Do you eat a wide variety of foods? ☐Yes ☐No ☐Unsure

How often do you consume sugar? ☐Daily ☐3-4 times/week ☐Occasionally ☐ Seldom/Never

Do you consider yourself: ☐Underweight ☐Overweight ☐Just right

How many times have you tried to lose weight ? _____

Age of first attempt: _____ What did you try? _____

Have you ever used any of the following for weight control? If yes, please explain.

Commercial diet programs	☐Yes	☐No	_____
Liquid diets	☐Yes	☐No	_____
Fad diets	☐Yes	☐No	_____
Prescription diet pills	☐Yes	☐No	_____
Over-the-counter diet pills	☐Yes	☐No	_____
Laxatives	☐Yes	☐No	_____
Diuretics	☐Yes	☐No	_____
Ipecac Syrup	☐Yes	☐No	_____
Vomiting	☐Yes	☐No	_____
Self Designed Program	☐Yes	☐No	_____
Restricted Calorie Diet	☐Yes	☐No	_____
Other	☐Yes	☐No	_____

Do you experience periods in which you eat uncontrollably? ☐Yes ☐No

How often? _____

How much time goes by between meals on average? _____

Please specify how many of the following you drink per week?

_____ Alcohol	_____Coffee	_____Decaf Coffee	_____Diet drinks/aids
_____Fruit Juice	_____Black Tea	_____Green tea	_____Sports drinks
_____Herbal Tea	_____Soft Drinks	_____Diet soft drinks	_____Water

Patient Health History

Health Concerns: Please list your main health concerns in order of importance.
Describe your primary concerns_____
When did it start? _____ Has this been diagnosed ☐ Yes ☐ No
Diagnosis _____
Are you currently receiving any treatment for this condition? Please describe:

_____

_____

Other Concerns: _____

What would you most like to accomplish on your first visit? _____

_____

Height:_____ Blood type: _____
Weight: Current_____ Last Year_____Ideal_____ Highest Weight_____

Have you recently lost/gained weight? ☐Yes ☐No _____
Was this an intentional change? ☐Yes ☐No
Did you weigh yourself? ☐Yes ☐No How often? _____
Are you concerned with your weight ☐Yes ☐No

Allergies
Please list any allergies you have to medications, environment and food. What is your reaction?

Allergen	Reaction
_____	_____
_____	_____
_____	_____

Medications:
List all prescriptions, over-the-counter medications:

Medications	Reason	Dosage	Date Began	Effective Y/N

Please attach a separate sheet if necessary to list all medications

Lifestyle Habits:
Occupation: _____ Hours per week: _____
Relationship Status: ☐Single ☐Married ☐Partnership ☐Divorced ☐Separated ☐Widowed
With whom do you live? ☐Spouse ☐Partner ☐Parents ☐Friends ☐Children ☐ Alone
Are you sexually active? ☐Yes ☐No
Do you or your partner use contraception? ☐Yes ☐No if so, what type(s)? _____
Are you pregnant? ☐Yes ☐No ☐Not sure Number of children_____

Social History

Do you use tobaccos products? ☐Yes ☐No Which ones (cigarettes, chew, etc)? _____

Did you use tobacco products in the past? ☐Yes ☐No For how long? _____

Do you drink alcohol? ☐Yes ☐No How many alcoholic beverages per week? _____

History of alcoholism? ☐Yes ☐No Have you ever received treatment? ☐Yes ☐No

Do you use any recreational drugs? ☐Yes ☐No Which ones? _____

History of drug addiction? ☐Yes ☐No Have you ever received treatment? ☐Yes ☐No

How many hours of sleep do you get on average? _____ Do you have trouble falling asleep? ☐Yes ☐No

Or staying asleep? ☐Yes ☐No Do you wake feeling refreshed? ☐Yes ☐No

What are your hobbies? _____

What is your current stress level? ☐Mild ☐Moderate ☐Severe

Past Medical History

Which of the following conditions have you had? Please check:

☐Abscesses	☐Asthma	☐Cancer	☐Chicken Pox	☐Cold sores
☐Diabetes	☐Eating Disorder	☐Epilepsy	☐Gallstones	☐Goiter
☐Heart Disease	☐Hepatitis	☐Kidney Disease	☐Leukemia	☐Malaria
☐Measles	☐Mononucleosis	☐Mumps	☐Parasites	☐Peritonitis
☐Pleurisy	☐Pneumonia	☐Prostatitis	☐Rheumatic fever	☐Skin disease
☐Stroke	☐Tonsillitis	☐Tuberculosis	☐Typhoid	☐Warts
☐Worms	☐Lactose Intolerant	☐Pelvic Inflammatory Disease		

☐Other: _____

Family History

Does anyone in your family have a history of the following? (please check)

☐Heart Disease	☐Asthma	☐Kidney Disease	☐High blood pressure
☐Anemia	☐Hay fever/Hives	☐Mental Illness	☐Alcoholism/Drug Addiction
☐Arthritis	☐Lung Disease	☐Osteoporosis	☐Alzheimer's
☐Depression	☐Stroke	☐Thyroid Disease	

Cancer(Type) _____ Diabetes(Type) _____

Any other relevant family history? _____

Exercise:

Are you currently exercising: ☐ Yes ☐ No
List type, duration, frequency and intensity of exercise activities:

_____

_____

Have you exercised in the past year? ☐ Yes ☐ No
Do you have any physical conditions that limit your ability/safety to exercise? ☐ Yes __ No
Please specify: _____

Nutrition Information

On a scale 1 -10 (10 being extremely healthful), how do you rate your diet?_____
Please describe any current dietary restrictions that you may have (vegan/vegetarian/celiac)

_____

Do you have any food allergies? ☐ Yes ☐ No If yes, please describe _____

_____

Have you made any recent changes to your diet? ☐ Yes ☐ No If yes, please describe_____

_____

What foods do you consume on a regular basis?_____

_____

What top five foods do you crave? _____

_____

What top five foods do you avoid? _____

-_____

Do you snack during the day? ☐ Yes ☐ No What:_____

How many times per week do you eat breakfast? _____
Please specify how many times you eat the following meals out to eat per week:

_____Breakfast _____Lunch _____Dinner

How many days do you eat: _____ Breakfast _____Lunch _____Dinner
List restaurants you usually choose: _____
Do you generally cook your own meals? ☐ Yes ☐ No How often? _____
Do you like to cook? ☐ Yes ☐ No _____
Where do you do most of your grocery shopping? _____

What do you know about Dr. Jamie's approach to health? _____

_____

What three expectations do you have from this visit to our clinic?

1. _____
2. _____
3. _____

What expectations do you have of me personally as your physician?

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Please check the box that is most appropriate. (Rate from 0 to 10, 10 being 100% committed.)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

_____

_____

What behaviors or lifestyle habits do you currently engage in that are detrimental to your health?

_____

_____

What potential obstacles do you foresee that may interfere with adhering to any therapeutic treatment we will be sharing with you? _____

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes will be making? _____

_____

What do you LOVE to do? _____

List all supplements you are currently taking (herbal, hormonal, homeopathic, vitamin, mineral) and bring all current supplement bottles to your Initial appointment.

_____

_____

_____

Digestive Screening Questionnaire

History		
Yes ☐	No ☐	Have you had your zinc levels checked in the last 6 months
		How many glasses of water do you drink per day (please indicate a#)
		How many servings of fruit do you Eat each day (please indicate a#)
Yes ☐	No ☐	Do you eat sushi
Yes ☐	No ☐	Do you consume any dairy products
Yes ☐	No ☐	Have you taken antibiotics in the last 6 months or for an extended period of time during the last 10 years
Yes ☐	No ☐	Have you traveled out of the country in the last 10 years
Yes ☐	No ☐	Have you ever had any type of food allergy/sensitivity testing performed
Have you been diagnosed with any of the following		
Yes ☐	No ☐	Ulcers – gastric duodenal
Yes ☐	No ☐	GERD/Reflux
Yes ☐	No ☐	Pancreatitis
Yes ☐	No ☐	Celiac Disease
Yes ☐	No ☐	IBS/IBD/Colitis
Do you take		
Yes ☐	No ☐	OTC antacids
Yes ☐	No ☐	OTC laxatives/ Fiber
Yes ☐	No ☐	Other digestive aids used (please list):
Yes ☐	No ☐	Prescription medicines for digestion (please list)

Upper GI – Burning, Gerd, Indigestion		
Yes☐	No☐	My stomach burns / hurts even when empty. (Not hunger pangs)
Yes☐	No☐	Eating or dinking relieves above
Yes☐	No☐	My stomach starts burning or I get bloated immediately after or while eating or drinking
Yes☐	No☐	My stomach starts burning or I get bloated 30 min to several hours after I eat or drink
Yes☐	No☐	Certain foods seem to make this worse (please list)
		What relieves this? (please list)
Yes☐	No☐	I have been diagnosed with “Reflux” or “GERD”
Yes☐	No☐	Is the pain all the time

Lower GI – Gas, Bloating, Cramping, Constipation, Diarrhea		
Yes☐	No☐	I have at least 1 normal bowel movement each day. Normal is a large, med. brown, well formed stool w/o cramping, strain or pain
My stools are often:		
Yes☐	No☐	Small and round or hard
Yes☐	No☐	Thin – pencil – like
Yes☐	No☐	Pasty or fatty
Yes☐	No☐	Loose
Yes☐	No☐	Very foul
		I often get really gassy and:

Yes ☐	No ☐	It's not nice but not really offensive
Yes ☐	No ☐	Very offensive and embarrassing
Yes ☐	No ☐	Do any foods aggravate? Please list
Yes ☐	No ☐	I often have to strain to have a bowel movement
Yes ☐	No ☐	I often have cramping and pain with a bowel movement
Yes ☐	No ☐	I often have abdominal cramping and pain even without a bowel movement.
Yes ☐	No ☐	I notice undigested food in my stool – especially vegetable matter.

Please list the following as it applies:

Prescription medicines for digestion:

Foods that male GERD, heartburn worse:

What relieves heartburn or GERD:

Please list any emotional traumas you may have suffered and at what age they occurred. Use a separate piece of paper if needed. Emotional factors can play a significant role in setting the body up for illness.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Life Satisfaction

Please give each area of your life a number from 1 to 100 to indicate how satisfied you are with that area of your life. For example, if you are extremely happy with you career, give it a 100, if you are somewhat happy with your career give it a 50 and if you feel dissatisfied with your career, give it a 0. Try to answer how you feel overall, not just for today.

Significant Other/ Romance _____ Physical Environment _____ Fun and Recreation _____ Money ____
Personal Growth _____ Family and Friends _____ Spiritual Life _____ Career _____ Health _____

How did you hear about us? _____

Please sign and date, indicating that you are consenting to treatment at Goodhealth Chiropractic.

Signature: _____ Date:_____

Please bring any recent lab work or imaging results you have to your initial visit.
Thank you for taking the time to fill out this form. I realize it is long, and appreciate your responses. This information allows me to provide you with the best possible healthcare. Please feel free to ask any questions along the way. I look forward to working with you.

Dr. Jamie Gutheil D.C.

Please fill out forms before your visit.
Bring forms with you to your visit or they can be mailed to drjamedc@gmail.com or mailed to:

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