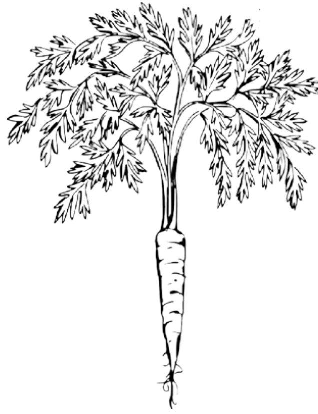

Adult Intake Form

InsightfulNUTRITION

Evidence-Based Clinical Nutrition

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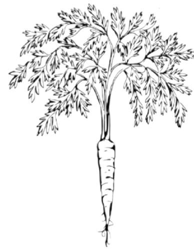

OPERATIONAL GUIDELINES

1. “I am not a medical doctor. I am not legally permitted to treat diseases. I can however, advise you with respect to building and maintaining wellness.”

2. “If you have a condition requiring medical attention, it is a matter between you and your medical doctor. Legally, I am not permitted to advise you on it. My concern is to help you to discover and support your unique nutritional weaknesses.”

3. “I am not legally authorized to diagnose your condition. For that you need to consult a licensed physician. I can, however, give you guidance about giving your body the nutrients it needs to do its own normalizing, regardless of what condition it may be in.”

NUTRITIONAL CLIENT STATEMENT

I hereby attest to the following:

1. I fully understand that Helen Papaconstantinos is not a medical doctor and I am not here for medical diagnostic or treatment procedures.

2. The services provided by Helen Papaconstantinos are at all times restricted to consultation on the subject of nutritional matters intended for general nutrition well-being and do not involve the diagnosing, prognosticating, treatment, or prescribing of remedies for the treatment of any disease, or any licensed or controlled act which may constitute the practice of medicine in this province.

Signature: ______________________ Name: ______________________

Daytime Phone: ______________________ Evening Phone: ______________________

Address: ____

____

City: ______________________ Province: ____________ Postal Code: ____________

Date: ____________ Email: ______________________

HEALTH INFORMATION - CONFIDENTIAL

Age:__________ Sex:________ Height:________ Weight:_________ BMI:_______ Blood Type:_______________

Date of Birth: _____________ Your Occupation / Environment: ____________________________________

MAIN HEALTH COMPLAINT ____

When did your condition or illness first begin?

____

Other problems related to the concern:

____

How often does this occur?

____

Rate the intensity of the concern: Good Bad

1 2 3 4 5 6 7 8 9 10

Things that relieve problem:

____

Things that make problem worse:

____

Previous treatments for this concern:

____

Please list your top 3 health goals in order of importance to you:

1. ____
2. ____
3. ____

Secondary Health Concerns or Medical Conditions (Including Treatments Received)

1. ____
2. ____
3. ____

Other Health Care Providers (Chiropractic, Physiotherapeutic, etc) Attach extra sheets as needed.
Name/ Address / Contact # / Type of Practitioner

1. ______________________________

2. ______________________________

MEDICATIONS AND OVER - THE - COUNTER PRODUCTS

Please list **ALL** current medications (prescription, over-the-counter, etc) and include the dosage, frequency, duration and the reason(s) for taking them.

Medication	Dosage	Frequency ie: 2X/day, with food	Duration ie: May 12-25	Reason / Condition for taking:

Please use an additional sheet of paper if needed.

Allergies / Reactions to meds:

____

____

NATURAL HEALTH PRODUCTS

Please list **ALL** current natural products (supplements, botantical tinctures, herbs, teas, homeopathics etc.) and include the dosage, frequency, duration and the reason(s) for taking them.

Natural Health Product	Dosage	Frequency ie: 3X/day, empty stomach	Duration ie: taking for 1 month	Reason / Condition for taking:

Please use an additional sheet of paper if needed.

Allergies / Reactions to natural health products:

____

____

FAMILY HISTORY

Hereditary diseases? (I will design your protocol with “preventative nutrition” in mind)

Father - Age:______ Health Status:

____

Mother - Age:______ Health Status:

____

Brother - Age:______ Health Status:

____

Sister - Age:______ Health Status:

____

Have you ever been hospitalized? If yes, when? Why?

____

____

Surgeries (Appendix, GB, Tonsils):

____

____

Traumas or Concussions in the past?

____

____

Vaccinations or Flu shots and when?

____

____

Other Health Information:

____

____

ADDITIONAL NOTES:

LIFESTYLE ASSESSMENT SECTION

Are there any foods you avoid for personal or religious reasons? ______________________

How many cups / glasses of water or other liquids do you drink, **on average per DAY**?

Coffee: ________ Tea: ________ Tap Water: ______ Filtered Water: ______ Other Water: ______ Milk: ________

Wine: ________ Fruit Juice: ________ Vegetable Juice: ______ Juicer: ______ Beer: ________ Liquor: ________

Herbal Tea: ________ Soft Drinks: ________ Other: ______ Chew Gum: ________

Do you smoke? ☐ Yes ☐ No If yes, how many per day? ______________________

Have you ever smoked? ☐ Yes ☐ No If yes, for how long? (yrs) ________

How many hours of sleep do you get on average? ________ Do you awake feeling rested? ☐ Yes ☐ No

How many hours do you work each day? ______ How many hours do you spend in front of a computer? ______

How many hours a day do you watch tv? ______ How many hours a day do you read? ________

Is there mold in your home? ☐ Yes ☐ No

Do you have pets? ☐ Yes ☐ No If yes, what are they? ______________________

What do you do for exercise? Please indicate type, how often and for how long?

____

____

____

DIETARY HISTORY (PAST 5 YEARS) ASSESSMENT SECTION

Breakfast	Lunch	Dinner	Snacks
1	1	1	
2	2	2	

NOTE: CLIENTS WITH DIGESTIVE ISSUES, AUTO-IMMUNE CONDITIONS, AND COMPLEX HEALTH CONCERNS WILL BE ASKED TO COMPLETE A 5-DAY DIET DIARY

Favorite Food(s) you crave often?

____

____

List any foods you react adversely to?

____

____

Are there any other concerns that you would like to discuss that were overlooked on this form?

____

____

____

____

What obstacles do you foresee in your healing process? (I will try to design your protocol with this in mind)

____

____

____

____

How committed are you?

Not Committed									Very Committed
1	2	3	4	5	6	7	8	9	10

SYMPTOMATOLOGY ASSESSMENT SECTION

Based upon your typical health profile and current health status; rate each of the following symptoms according to the following point scale. Do you suffer from or have a history of any of the following conditions or symptoms?

0 = Never have it – if so, leave the space blank
1 = Mild or Occasionally have it
2 = Moderate, Happens more frequently
3 = Severe, Happens all the time
4 = Extremely severe, Always Present

3rd 2nd 1st Visit #
___ ___ ___ Anemia (low hemoglobin / ferritin)
___ ___ ___ Arthritis (Osteo or Rheumatoid)
___ ___ ___ Heart Condition/Angina Pectoris/Stroke
___ ___ ___ Candida / Dysbiosis
___ ___ ___ Colon Cancer / Disease
___ ___ ___ Chronic Fatigue / Fibromyalgia

3rd 2nd 1st Visit #
___ ___ ___ Hyperthyroid (Graves Disease)
___ ___ ___ Hypothyroid (low)
___ ___ ___ Obesity
___ ___ ___ Osteoporosis / Osteopenia
___ ___ ___ Cancers or Tumors – Dx __ Stage __
___ ___ ___ Other: ____________________

Heart

___ ___ ___ Heart Palpitations / tachycardia (racing)
___ ___ ___ Low Blood Pressure
___ ___ ___ High Blood Pressure
___ ___ ___ Tingling arms or legs
___ ___ ___ Arms and legs often go to sleep
___ ___ ___ Chest Pain or Tightness

Circulation

___ ___ ___ Weakness or Low Energy
___ ___ ___ Circulation problems
___ ___ ___ Cold hands & feet
___ ___ ___ Edema (water retention)
___ ___ ___ Leg / Ankles swelling
___ ___ ___ Ringing in ears (Tinnitus)
___ ___ ___ Diabetes (Type I or Type II)

Blood Sugar

___ ___ ___ Hypoglycemia
___ ___ ___ Dizzy periods or blackouts
___ ___ ___ Sudden weakness & shakiness
___ ___ ___ Experience hunger after eating
___ ___ ___ Experience hunger almost constantly
___ ___ ___ Irritable if late for or missed meal
___ ___ ___ Craving for sweets, alcohol, coffee
___ ___ ___ Wake up at night feeling hungry
___ ___ ___ Overweight, can't lose
___ ___ ___ Feel better when don't eat
___ ___ ___ Poor appetite / picky eater
___ ___ ___ Anorexia / Bulimia

Immune

___ ___ ___ Frequent colds or infections:
How many a year? ___ Flu shots? ___
___ ___ ___ Antibiotics ___# of times in past 5 yrs
___ ___ ___ Cortisone / NSAIDS / Analgesics
# of years? ___ How often? ___ wk / ___ mn

Respiratory

___ ___ ___ Asthma
___ ___ ___ Bronchitis
___ ___ ___ Coughing / Wheezing
___ ___ ___ Difficulty breathing

Allergies

___ ___ ___ Allergy / Hay fever
___ ___ ___ Sinus or Ear infections
___ ___ ___ Bags or dark circles under eyes
___ ___ ___ Itchy, stuffy or runny nose
___ ___ ___ Nose-throat congestion / mucus (type?)
___ ___ ___ Post-nasal drip

Eyes

___ ___ ___ Dry / Irritated or Itchy eyes
___ ___ ___ Problems w/ eyesight / Glaucoma / MD

Ears

___ ___ ___ Problems with hearing

Connective Tissue

___ ___ ___ Joints pop or crack
___ ___ ___ Back pain
___ ___ ___ Neck or shoulder tension / pain
___ ___ ___ Achy or weak legs
___ ___ ___ Any other muscle pain?
___ ___ ___ Any other joint condition?
____

Nervous System

___ ___ ___ Concentration or memory problems
___ ___ ___ Sleepiness (in afternoon? / After meals?)
___ ___ ___ ADHD / Hyperactivity
___ ___ ___ ADD / Attention deficit syndrome
___ ___ ___ Migraines
___ ___ ___ Headaches – Throbbing / Stabbing
___ ___ ___ Insomnia – fall asleep / stay asleep
___ ___ ___ Restless sleep / other sleeping problems
___ ___ ___ Restless leg syndrome
___ ___ ___ Nightmares
___ ___ ___ Mood swings
___ ___ ___ Anxiety / panic attacks
___ ___ ___ Irritability / Nervousness
___ ___ ___ Depression / Sadness
___ ___ ___ Frustration / Anger

Digestion

___ ___ ___ Liver or Gall Bladder problems
___ ___ ___ Nausea or Vomiting
___ ___ ___ Ulcers / Gastritis (in past or present)
___ ___ ___ Bad breath
___ ___ ___ Heartburn / Gastric Reflux - GERD
___ ___ ___ Belching / Burping
___ ___ ___ Gas and bloating – how soon after meals?
___ ___ ___ Gas and bloating – on empty stomach
___ ___ ___ Stomach cramps / Abdominal pains
___ ___ ___ Diarrhea ______
___ ___ ___ Constipation
Bowel movements per day _____?
___ ___ ___ Hemorrhoids / Varicose Veins
___ ___ ___ Celiac Disease
___ ___ ___ Ulcerative Colitis / Crohn's Disease
___ ___ ___ Irritable Bowel Syndrome (IBS)
___ ___ ___ Diverticulosis / itis
___ ___ ___ Itchy anus, nose or ears
___ ___ ___ Any other gastrointestinal condition?
____

Vitamin C / Bioflavonoids

___ ___ ___ Bruise easily
___ ___ ___ Gums bleed easily
___ ___ ___ Nose bleeds easily past/present
___ ___ ___ Kidney / Bladder problems / infections
___ ___ ___ Chemical sensitivity, perfume, gas, bleach
___ ___ ___ Swollen or tender glands

Skin/Hair/Nails

___ ___ ___ Acne / Goosebumps on triceps
___ ___ ___ Psoriasis / Eczema
___ ___ ___ Hives
___ ___ ___ Dermatitis
___ ___ ___ Fungal infections (athletes foot / jock itch)
___ ___ ___ Skin infections / Rashes
___ ___ ___ Itching skin
___ ___ ___ Dry skin / Scaling skin
___ ___ ___ Any other skin condition?
____
___ ___ ___ Loss of hair
___ ___ ___ Nails break, split, or peel
___ ___ ___ White spots on nails

BOWEL HEALTH

Frequency	Consistency	Contents	Length	Width	Texture	Color	Time	Toliet p.
☐ 1+	☐ Hard & Dry	☐ Stringy / Mucous	☐ 6"	☐ 3/4 "	☐ Smooth well formed	☐ Light Brown	☐ < 5 min	☐ Almost None
☐ Daily	☐ Firm	☐ Floating (fat)	☐ 3-5 "	☐ Pencil Thin	☐ Thready loose	☐ Yellowish Brown (liver/GB)	☐ 5-15	☐ A Little
☐ Every 2 days	☐ Soft	☐ Blood	☐ Less than 3"	☐ Pellets	☐ Lumps pressed together	☐ Dark Brown	☐ >15	☐ Lots
☐ Weekly	☐ Watery	☐ Undigested Food	☐ Small Bits	☐ Varies		☐ Green		
☐ < Weekly		☐ Sink (Slow Transit)				☐ Black		

Summary: ____

____

Females Only:

How long does your period last _____# of days

Flow? heavy light Clotting? ____ Color ____

___ ___ ___ P.M.S.– A C D H – Day ____to____?
___ ___ ___ Dysmenorrhea – Day ____to____?
___ ___ ___ Mennorhagia – Day ____to____?
___ ___ ___ Cycle Irregularities / Amenorrhea–P / S
___ ___ ___ Yeast Infections / Vaginal-itch or discharge
___ ___ ___ Birth control Pill – age ____to____?
___ ___ ___ Difficulty conceiving / Infertility– Age___?
___ ___ ___ Miscarriage – Age___?
___ ___ ___ Hysterectomy – Age___?
___ ___ ___ Endometriosis – Age___?
___ ___ ___ Uterine fibroids – Age ___ ? Size ___?
___ ___ ___ Ovarian Cysts – L / R Size ___? #___?
___ ___ ___ Cervical Dysplasia – Age ___?
___ ___ ___ Fibrocystic Breasts - L / R – Age ___?
___ ___ ___ Menopausal discomfort / Hot flashes
___ ___ ___ Decline in sexual interest, feelings
___ ___ ___ Pregnant or lactating
___ ___ ___ Breast cancer Dx _____ Stage _____

Males Only:

___ ___ ___ Difficult urination, starting or burning
___ ___ ___ Get up at night to urinate #_______ ?
___ ___ ___ Back or Leg pains
___ ___ ___ Prostate trouble
___ ___ ___ Diminished sex drive or Impotence
___ ___ ___ Poor sexual performance
___ ___ ___ Infertility
___ ___ ___ Prostate cancer

ADDITIONAL NOTES:

____
____
____
____
____
____
____
____