

Adult Intake Form

InsightfulNUTRITION

Evidence-Based Clinical Nutrition

Helen Papaconstantinos, Ba(H), ROHP, CNP
Registered Orthomolecular Health Practitioner
Registered Nutrition Counseling Practitioner
Certified Nutritional Practitioner

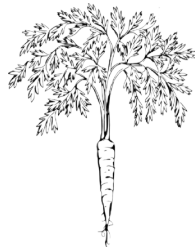
www.insightfulnutrition.ca

info@insightfulnutrition.ca

416-454-0131

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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, botanical 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

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

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)

Respiratory

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

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

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
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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?
-

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

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

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

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?
-

BOWEL HEALTH

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