Intuitive Nutrition LLC

Client Questionnaire

Welcome! Please complete this form prior to our first meeting if at all possible. It should take 30-45 minutes to complete, and I'll get a notification when you're finished. You're welcome to skip questions if you're not comfortable answering them.

From your Practice Better dashboard, you should see a food journal. If you're able to log your meals for 24 hours (or more) prior to our visit, that would be extremely helpful. If not, no worries! I'm looking forward to working together. Reach out any time with questions.

Personal Information

First name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Occupation

Hours per week

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Primary Care Provider

Note that I will not contact other providers regarding our work together without your express consent. Providing one or more ways to contact your other providers facilitates this process if you wish for us to be in contact.

Title | First name | Last name

Work phone | Mobile phone | Fax number

Email address

Title/Occupation

Are you working with other practitioners?

This includes specialists and providers such as massage therapists, acupuncturists, therapists/counselors, etc.

○ Yes ○ No

List the other practitioners that support you:

Name	Type of Practitioner	How long?

Goals and Concerns

Why did you decide to schedule a nutrition appointment with me?

Untitled section

List your most pressing health concerns:

	Health Concern	Why is this a problem for you/How does this impact	How long has this been going on?
1.			
2.			
3.			

Medical History

Please check health conditions that you've experienced and/or that a provider has diagnosed and provide the date of onset.

Gastrointestinal Health

	Past	Now	Date of onset/notes
Celiac Disease	☐	☐	
Crohn's Disease	☐	☐	
Gastric or peptic ulcer	☐	☐	
GERD/heartburn/reflux	☐	☐	
Irritable Bowel Syndrome	☐	☐	
Liver Disease	☐	☐	
Small Intestinal Bacterial Overgrowth (SIBO)	☐	☐	
Ulcerative Colitis	☐	☐	
Excessive Gas/Bloating	☐	☐	
Excessive Bowel Movements/Diarrhea	☐	☐	
Infrequent Bowel Movement/Constipation	☐	☐	
Foul smelling gas	☐	☐	
Undigested food in stool/malabsorption	☐	☐	

Respiratory Health

	Past	Now	Date of onset/notes
Asthma	☐	☐	
Bronchitis	☐	☐	
COPD	☐	☐	
Emphysema	☐	☐	
Pneumonia	☐	☐	
Sleep Apnea	☐	☐	
Tuberculosis	☐	☐	
Shortness of breath after exertion	☐	☐	

Musculoskeletal/Pain/Autoimmune:

	Past	Now	Date of onset/notes
Chronic Fatigue Syndrome	☐	☐	
Epstein-Barr Virus	☐	☐	
Fibromyalgia	☐	☐	
Graves Disease	☐	☐	
Hashimoto's Thyroiditis	☐	☐	
Herpes	☐	☐	
Lupus/SLE	☐	☐	
Lyme Disease	☐	☐	
Migraines/Headaches	☐	☐	
Osteoarthritis	☐	☐	
Rheumatoid Arthritis	☐	☐	

Other musculoskeletal symptoms of note or concern:

Neurological and Mental Health

	Past	Now	Date of onset/notes
ADD/ADHD	☐	☐	
Addiction or Substance Abuse	☐	☐	
Alzheimer's Disease	☐	☐	
ALS	☐	☐	
Anorexia	☐	☐	
Autism Spectrum Disorder	☐	☐	
Anxiety	☐	☐	
Bulimia	☐	☐	
Depression	☐	☐	
Other Eating Disorder	☐	☐	
Parkinson's Disease	☐	☐	
Seizures	☐	☐	

Stroke	☐	☐	
Suicidal thoughts or ideation	☐	☐	

Blood/Cardiovascular Health

	Past	Now	Date of onset/notes
Anemia	☐	☐	
Atherosclerosis	☐	☐	
Beta-thalassemia	☐	☐	
Elevated Cholesterol	☐	☐	
Heart Attack/MI	☐	☐	
High Blood Pressure/Hypertension	☐	☐	
Irregular Heart Beat	☐	☐	
Low Blood Pressure/Hypotension	☐	☐	
Coagulopathy	☐	☐	

Urinary/Gynecological Health

	Past	Now	Date of onset/notes
Endometriosis	☐	☐	
Kidney Stones	☐	☐	
PCOS	☐	☐	
Uterine Fibroids	☐	☐	
Urinary Tract Infections	☐	☐	
Yeast Infections	☐	☐	

Sexual Health

Do you experience any of the following?

☐ Low libido
☐ Difficulty reaching orgasm
☐ Pain with sex
☐ Vaginal dryness

Cancer/Family history of Cancer

Type	Treatment	Relation

Metabolic/Endocrine

	Past	Now	Date of onset/notes
Diabetes, Type I	☐	☐	
Diabetes, Type II	☐	☐	
Hypoglycemia	☐	☐	
Hypothyroidism/Hashimoto's Thyroiditis	☐	☐	
Hyperthyroidism	☐	☐	
Metabolic Syndrome (pre-diabetes, insulin resistance)	☐	☐	

Dermatological

	Past	Now	Date of onset/notes
Acne	☐	☐	
Eczema/Atopic Dermatitis	☐	☐	
Psoriasis	☐	☐	
Rosacea	☐	☐	
Rash	☐	☐	

Describe any additional medical or health concern:

Do you experience any of the following symptoms?

- ☐ Hot flashes
- ☐ Vaginal dryness
- ☐ Weight gain
- ☐ Cognitive changes (forgetfulness, etc)
- ☐ Changes in mood
- ☐ Hair loss or thinning

Birth History and Childhood Health

Your birth:

- ◯ Vaginal
- ◯ C-Section
- ◯ Unknown

How would you rate your health as a child?

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Please describe any health challenges or significant experiences from childhood.

Family History

Please note any history of the following conditions within your family of origin: fibroids, endometriosis, miscarriage, stillbirth, clotting disorder, heart disease, cancer, stroke, high blood pressure, lung disease, kidney disease, diabetes, mental illness/addiction, and any other significant illness/condition.

Family Member	Health Condition	Deceased?
		☐
		☐
		☐
		☐
		☐

Known genetic disorders (polymorphisms, etc)

Allergy Information

Do you experience any food, environmental, seasonal or other allergies? ◯ Yes ◯ No

Please describe any allergies, including the substances to which you are allergic and any symptoms you experience.

Medications + Supplements

Please list all prescription and over-the-counter medications you use, as well as any nutritional supplements and herbs you are currently taking.

Medication Name	Dosage/Frequency	Reason	Duration

Herbs and Nutritional Supplements

Supplement Name (include brand)	Dosage/Frequency	Reason	Duration
			☐
			☐
			☐
			☐

Have you had prolonged or regular use of NSAIDs (Advil, Aleve, Motrin, Aspirin, Tylenol)?

Please describe:

Have you had prolonged or regular use of opioid pain killers?

Please describe:

Have you had prolonged or regular use of proton pump inhibitors (PPI) or acid-blocking drugs?

Please describe:

Antibiotic use? (>1 time per year)

Please describe:

Surgeries/Hospitalizations

Please list any previous injuries, surgeries, and hospitalizations; provide the date and your age, if known.

Diagnostic Studies/Labs

If you have lab work or other test results that you'd like to share, you can upload them to your "Documents" from the Practice Better dashboard

Diagnostic/Labs

Please list any recent lab work or diagnostic studies that you'd like to bring to my attention. If there are any results that concern you, please note them here.

Nutritional History

Have you ever had a nutritional consultation? ○ Yes ○ No

Have you made any changes to your eating habits because of your health? ○ Yes ○ No

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

How would you rate the quality of your diet over the past month?

1 = Poor, 5 = Excellent

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

How many servings of fruit/vegetables do you currently eat each day?

1 serving= 1/2 cup or size of your palm

- ◯ 8+
- ◯ 5-7
- ◯ 3-4
- ◯ 0-2

Height + Weight

Please feel free to skip any questions about weight if you prefer not to answer them. We will only address weight loss if this is one of your goals.

Height:	
Current Weight:	
Usual Weight:	
Desired/Goal weight	
Weight 1 year ago:	

Have you recently lost or gained a significant amount of weight?

Please describe:

What are your comfort foods?

How often do you eat out each week?

Include meals eaten in restaurants and take-out

What types of beverages do you consume?

	Rarely/Never	Weekly	Several times/week	Daily	Several times/day
Tap or filtered water	◯	◯	◯	◯	◯
Coffee	◯	◯	◯	◯	◯
Caffeinated tea	◯	◯	◯	◯	◯
Soda	◯	◯	◯	◯	◯

Sparkling water	○	○	○	○	○
Herbal tea	○	○	○	○	○
Wine	○	○	○	○	○
Beer	○	○	○	○	○
Liquor	○	○	○	○	○
Juice	○	○	○	○	○
Cow's milk	○	○	○	○	○
Plant-based milk (almond, soy, etc)	○	○	○	○	○
Sports drinks	○	○	○	○	○

Do you filter your water in your home? ○ Yes ○ No

How many 8 ounce glasses of water do you drink each day, on average?

- ○ 9+
- ○ 6-8
- ○ 2-5
- ○ 0-1

Do you consume water or beverages in plastic bottles/containers? ○ Yes ○ No

Check all of the factors that apply:

- ☐ Fast eater (>15 min/meal)
- ☐ Eat too much/overeat
- ☐ Do not enjoy cooking
- ☐ Family members have different dietary needs or preferences
- ☐ Eat meals mostly alone
- ☐ Rely on convenience items
- ☐ Emotional eating
- ☐ Drink too much alcohol (<5-7 drinks/week)
- ☐ Forget to eat
- ☐ Long hours between meals (<7 hours)
- ☐ Late night eating/eating 2 hours before bed
- ☐ Crave or eat too much sugar/sweets
- ☐ Negative relationship with food
- ☐ Do not plan meals or menus
- ☐ Not enough time to cook or eat healthy
- ☐ Love to eat/"foodie"
- ☐ Travel frequently
- ☐ Confused about nutrition advice
- ☐ "Hangry" or irritable when hungry

What questions do you have about your nutrition or eating patterns?

Lifestyle

When was the last time you felt well?

With whom do you live?
Include pets, children, roommates, partner/spouse, etc.

Do you engage in moderate physical activity for 20+ minutes on 3+ days per week?

Activity

	Low Intensity	Moderate Intensity	High Intensity	How often
Stretching/yoga	☐	☐	☐	
Cardio/Aerobics	☐	☐	☐	
Strength Training	☐	☐	☐	
Sports or Recreation	☐	☐	☐	
Walking	☐	☐	☐	

Do you have any issues that limit your physical activity? Please describe.

How often do you have a bowel movement?

Do you currently use cannabis or CBD? ○ Yes ○ No

Daily Stressors

Rate how stressful you find each of the following on a scale of 1-10. 1= not at all stressful; 10 = extremely stressful.

Stressors	
Work	
Family	
Social life	
Finances	
Health	

What activities do you do to relieve stress and/or relax?

What creative outlets do you have and/or what do you do for fun?

Sleep Health

How many hours do you sleep per night during the week or on workdays, on average?

- ◯ 10+
- ◯ 8-10
- ◯ 6-8
- ◯ Less than 6

How many hours fo you sleep per night on the weekend or on your days off, on average?

- ◯ 10+
- ◯ 8-10
- ◯ 6-8
- ◯ Less than 6

Sleep overview

	Yes	No	Notes/Comments
Do you have trouble falling asleep?	☐	☐	
Do you feel rested upon waking?	☐	☐	
Do you wake up during the night?	☐	☐	
Do you use anything to help you fall or stay asleep?	☐	☐	

How would you rate the overall quality of your sleep?

1 = Poor, 5 = Excellent

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Oral Health

Do you visit the dentist more than once/year? ○ Yes ○ No

Do you brush and floss regularly? ○ Yes ○ No

Do you have:

- ☐ Tooth pain
- ☐ Gingivitis
- ☐ Bleeding gums
- ☐ Frequent bad breath/halitosis
- ☐ TMJ
- ☐ Swallowing problems
- ☐ Chewing problems
- ☐ Mercury amalgams/fillings

Environmental History

Do you experience or have you been diagnosed with chemical sensitivities?
Please describe:

Are you exposed regularly to the following?

- ☐ Aluminum cookware
- ☐ Auto exhaust/fumes
- ☐ Hair dyes
- ☐ Fertilizers
- ☐ Lead paint or pipes
- ☐ Microwaves
- ☐ Perfumed/scented products
- ☐ Candles
- ☐ Paint fumes
- ☐ Pesticides or herbicides
- ☐ Pet dander
- ☐ Heavy metals
- ☐ Plastics (plastic cookware or containers)
- ☐ Nail polish/remover
- ☐ Paper receipts
- ☐ Dry cleaned laundry?

Readiness Assessment

If you had to guess, what two changes could you make now that would make the most difference in the way you feel?

As part of our work together, are you interested in:

- ☐ Dietary recommendations
- ☐ Supplement recommendations
- ☐ Recipes and product recommendations
- ☐ Herbal recommendations
- ☐ Coaching and motivation/accountability

How often do you anticipate needing or wanting to schedule appointments?

- ◯ I prefer to meet every 2-3 weeks to keep myself accountable and check in
- ◯ I anticipate needing to meet every month or two
- ◯ I just want a second pair of eyes on my plan; I don't anticipate needing additional support after the first two visits
- ◯ Not sure/whatever is recommended
- ◯ Other

When it comes to supplements:

Please check all that apply

- ☐ I prefer not to take them
- ☐ I am on a very tight budget and need to keep costs as low as possible
- ☐ I'd like more education on what supplements are recommended for my condition/concerns
- ☐ I wouldn't mind support of it makes sense for me and my lifestyle
- ☐ I am open to using herbal teas
- ☐ If it doesn't taste good, I'm not likely to take them
- ☐ I already take enough medications, I don't want to add more pills

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

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

	5	4	3	2	1
Significantly modify your diet	○	○	○	○	○
Keep a food journal	○	○	○	○	○
Track other inputs (e.g. mood, exercise, owes, etc)	○	○	○	○	○
Practice daily relaxation techniques	○	○	○	○	○
Take nutritional supplements as recommended	○	○	○	○	○

Thank you for taking the time to share a bit about your health history. Sometimes getting it all down on paper helps to clarify the situation and provides a foundation for the healing process. I'm looking forward to going over this information with you when we meet. If you have any questions before then, please send me a message.