Integrative Assessment

** indicates a required field*

Current Health Information

List Health Concerns

*** Primary concern**

*** Severity**

- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Disabling
- [ ] Intermittent

Previous treatment received:

*** Secondary Concern**

*** Severity**

- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Disabling
- [ ] Intermittent

Previous treatment received:

*** Have you ever participated in nutritional therapy before?**

*** What kinds of practitioners (formal/informal) have you worked with around food/diet/nutrition? (Ex: dietician, health coach, nutritionist, etc.)?**

*** List all conditions currently monitored by a Health Care Provider.**

List Daily Activities

* Work Hours and Schedule

* Do you now or have you ever worked night shift?

- [ ] Yes
- [ ] No

* Time spent at home/with family

* Time spent social/recreational

* How much time do you spend outside per day? How much per week?

* What time do you go to sleep and wake up on weekdays? Weekends?

* How do you reduce stress?

Do you experience pain? If so, how do you manage it?

Health History Please list and include dates and treatments received

Surgeries

Accidents

Major Illnesses

Women

Last Pap

First day of last menstrual period

Number of children

Number of pregnancies

Complications?

Use of contraceptives? What type?

Abortions/Miscarriages?

Exercise

*** What type of activity do you participate in? Please list time spent doing the activity (hours/minutes) and the frequency**

- [ ] Swim
- [ ] Bike
- [ ] Dance
- [ ] Garden
- [ ] Golf
- [ ] Hike
- [ ] Pilates
- [ ] Run
- [ ] Tennis
- [ ] Walk
- [ ] Weights
- [ ] Yoga
- [ ] Other
- [ ] Other

Family Medical History

Please list age, list of any illness, or if deceased, list cause of death and age of death

*** Mother:**

*** Father:**

* Siblings:

* Mother's parents:

* Father's parents:

Current Dietary Habits

Please list any specific diets that you are currently following, for example, vegan, vegetarian, Atkins, gluten-free, raw, GAPS, etc.

Please list any known food allergies or sensitivities

Food preparation

*** Who does the shopping for your household?**

- [ ] You
- [ ] Family member
- [ ] Friend
- [ ] Other

*** Do you eat out?**

- [ ] Yes
- [ ] No

*** What kind of places do you eat out at?**

*** Do you prepare your own food?**

- [ ] Yes
- [ ] No

*** Do you enjoy cooking?**

- [ ] Yes
- [ ] No

*** How much time do you spend preparing food each day?**

- [ ] Never
- [ ] 0-30 minutes
- [ ] 1 hour
- [ ] 2 hours
- [ ] 3 hours

Please select any of the following food symptoms that you experience on a regular basis:

- [ ] Stomach ache
- [ ] Sinus
- [ ] Fatigue
- [ ] Burping
- [ ] Flatulence
- [ ] Bloating
- [ ] Itching
- [ ] Flushing

Diet History

*** Were you breastfed?**

- [ ] Yes
- [ ] No

*** Use of antibiotics as a child?**

- [ ] Yes
- [ ] No

*** Use of antibiotics as an adult?**

- [ ] Yes
- [ ] No

Please list any other childhood illnesses and the age at which they occurred

Did you experience any eating disorders during adolescence?

* Briefly describe your family's eating habits and mealtimes (Did you eat as a family? Did you eat at a table or in front of the television? Did you have to prepare your own meals? Was there fighting at meal-time?)

* Do you use artificial sugars or drink diet beverages?

- [ ] Yes
- [ ] No

Pain and Conditions

Please describe the location and experience of pain:

* Rate your stress level as of today

*** Please check all current and previous conditions**

- [ ] Headaches
- [ ] Pain
- [ ] Sleep disturbances
- [ ] Fatigue
- [ ] Sinus trouble
- [ ] Head injuries,concussions
- [ ] loss of memory, confusion
- [ ] Chronic pain
- [ ] Depression
- [ ] Rashes
- [ ] Sensitivity to scents
- [ ] Heart disease
- [ ] Blood clots
- [ ] Stroke
- [ ] Lymphadema
- [ ] High or Low blood pressure
- [ ] Chest pain, shortness of breath
- [ ] Asthma
- [ ] Rheumatoid arthritis
- [ ] Spinal problems
- [ ] Disk problems
- [ ] Lupus
- [ ] TMJ/Jaw pain
- [ ] Spasms/cramps
- [ ] Stiff/painful joints
- [ ] Weak or sore muscles
- [ ] Neck, shoulder, arm pain
- [ ] Low back, hip, leg pain
- [ ] Bowel dysfunction
- [ ] Abdominal pain
- [ ] Ulcers/colitis
- [ ] Belching/gas within 1 hour of eating

- [ ] Heartburn/acid reflux
- [ ] Thyroid dysfunction
- [ ] Diabetes
- [ ] HIV/AIDS
- [ ] Reproductive problems
- [ ] Painful or emotional periods
- [ ] Cancer/tumors
- [ ] Not hungry in the morning
- [ ] Diarrhea
- [ ] Stomach upset by greasy foods
- [ ] Nausea
- [ ] Gallbladder attacks
- [ ] Pulse speeds after eating
- [ ] Airborne allergies/hives
- [ ] Crohn's disease
- [ ] Use over-the-counter pain medication
- [ ] Fungus or yeast infections

Meaning of Food

*** Please describe in a few sentences what food means to you. There may be positive and negative associations. There is not a right or wrong answer. For example, is food important to you? Are you preoccupied with it? Does it feel nourishing? Does food cause fear or discomfort?**

Motivation for Nutritional Change

* Identify three reasons to improve your diet:

* Identify three obstacles to improving your diet:

* Identify 3 goals to improve your diet (3 months, 6 months, and 12 months):

* Identify 3 goals for improving your food preparation (3 months, 6 months, and 12 months):