Initial Nutritional Evaluation
Appointment 1A Consultation

Name_____Date_____

Address_____

City_____State_____Zip_____ Phone (Home)_____

Cell Phone_____Work Phone_____

Email_____ Date of Birth_____ Ht____ Weight_____

Medications_____

Referred By: ___Physician ___ Friend, Relative or Co-Worker ___Internet ___Phone __Other:

RATE YOUR ENERGY LEVELS (SCALE Best: 10 –Worst: 0) 0 1 2 3 4 5 6 7 8 9 10

____ *ENERGY LEVELS:* ___*Morning* ___*Afternoon* ___ACTIVITY LEVEL ___EXERCISE LEVEL

WHAT MAIN HEALTH ISSUES DO YOU NEED HELP WITH?

CHECK ALL THAT APPLY TO YOU (SCALE Best: 10 -Worst: 0) 0 2 3 4 5 6 7 8 9 10

___Low Energy, Fatigue
___Weight
___Pain:_____
___Joint Pain
___Difficulty Walking or Moving
___Blood Pressure
___Blood Sugar
___Cholesterol
___ Asthma, Breathing Difficulty
___ Allergies:_____
___Allergies, Sinuses, Respiratory
___Skin Rashes or Breakouts
___Itching or Burning Anywhere
___ Heart Racing or Palpitations
___Swelling:_____
___Frequent Colds, Flu or Infections

___Sleeping Difficulty
___Mood Swings
___Anxiety/Nervousness
___Depression
___Dizziness, Vertigo
___Hot Flashes or Night Sweats
___ Focus/Concentration/Memory
___ Frequent Urination/Bladder Leakage
___PMS or Period Problems
___ Infertility Problems
___ Learning Difficulty/Hyperactivity
___Cold Hands or Feet
___ Erectile or Prostate Difficulty
___ Diarrhea ___Constipation ___Gas
___Bloating __Heartburn __Nausea
___Other Not Listed :_____

What is Your #1 Main Health Concern?

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