Sarah Senter, L.Ac., ACN
License # TX 00885

Nutrition & Food Therapy Health Intake

Important: The information in this form will help your practitioner (Sarah Senter, L.Ac) give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing or underlying role in the diagnosis and treatment of your problem.

All of the information provided is strictly confidential

Please also complete the General New Patient Forms

Name: ____ **Date:** ___________________

Please state the reason for your upcoming visit:

____
____
____

How severe are your symptoms at their worst?
1 Very Mild/Occasional 2 Mild 3 Moderate 4 Pretty Bad 5 Severe 6 Debilitating

What lifestyle changes or treatments have you tried to help your condition?
____
____
____

Eating Habits:
Do you skip meals? ____ Yes ____ No

How many days per week do you eat:

Breakfast: _______ Lunch: _______ Dinner:________

Do you snack? ____ Yes ____ No
If so, when?
____

Do you buy or pack your lunches?

____ Buy # days per week:____ ____ Pack # days per week:____

Do you eat out? ____ Yes ____ No
How many meals per week?____

What restaurants do you usually choose?
1. ______________________ 4. ______________________ 7. ______________________
2. ______________________ 5. ______________________ 8. ______________________
3. ______________________ 6. ______________________ 9. ______________________

Who usually prepares the food at home?

____

Who does the grocery shopping?

____

Do you enjoy cooking? ____ Yes ____ No
Please specify how many of the follow you drink *per day*:

______ alcohol ______ caffeinated coffee ______ decaf coffee
______ diet drinks/aids ______ diet soft drinks ______ fruit juice
______ green tea ______ herbal tea ______ regular soft drinks
______ regular tea ______ sports drinks ______ water

Please indicate any beverages that are not listed that you consume regularly:

____

Constitutional Type:

Do you have good energy levels?

____

Do you consider yourself a fast burner, or have what people call “fast metabolism”?

____

Do you find you need to eat often (every 2-3 hours) to avoid getting tired or irritable?

____

Do you find you gain weight easily, or need to exercise more rigorously to lose weight?

____

Does anyone in your immediate or extended family have Diabetes? If so, please list.

____

Do you consider yourself: ____ Overweight ____ Underweight ____ Just About Right

Do you have any of the following:
___ Constipation ___ Loose stools ___ Irregular Bowel Movements ___ Bloating
___ Gas ___ Indigestion ___ Acid Reflux ___ Acne ___ Headaches ___ IBS
___ Anxiety ___ Depression ___ Allergies ___ Insomnia ___ Fatigue ___ Pain

Have you struggled with being overweight & tried dieting in the past to lose weight?
If so, please list what diets you have tried, when, & for how long.

____
____
____
____

Have you been successful in losing weight with the above plans?

____
____

Do you have any known food allergies or sensitivities? ____ Yes ____ No
What are they? ____

Have you ever eliminated foods from your diet? ____ Yes ____ No
If so, which foods do you avoid and why?

1. ____
2. ____
3. ____
4. ____
5. ____

What nutritional supplements or herbs are you currently taking and why?

Supplement / Herb	Reason	Dosage/Duration of Use

Goals/Expectations:

Do you want to change your eating habits? ____ Yes ____ No
Why? ____

Do you have any expectations from your visit today? ____ Yes ____ No
What are they?____
____

Only one more thing to fill out…

Please describe a typical day of meals & routine in your life. Fill out the chart below as best you can:

Morning Routine: What time upon waking?
Breakfast Foods:
Snack between breakfast and lunch?
Lunch Foods:
Snack between lunch and dinner?
Dinner Foods:
Bedtime Routine: What time to bed?
Exercise or movement during the day not listed?

Thank you!