INITIAL INTERVIEW

Name: | Date: | Consultation Time:

To ensure the maximum benefit of Nutritional Therapy, it is important that your information is accurate and up-to-date. If you notice any changes to your health, begin taking new prescriptions, etc., please notify your Nutritional Therapy Practitioner (NTP) or Nutritional Therapy Consultant (NTC) as soon as possible. It is also your right as a client to access, update, or delete your records at any time. Though NTPs and NTCs are not HIPAA regulated entities, the Nutritional Therapy Association, Inc. (NTA) is committed to protecting client privacy and requires students and graduates to uphold the privacy best practices and the policies laid out in the U.S. *Standards for Privacy of Individually Identifiable Health Information*. Please see the *Disclaimer* for further details.

CONTACT INFORMATION

Address 1:

Address 2:

City: | State: | Zip:

Phone: | Type (Cell, Home, Work):

Email:

REFERRED BY

Name:

Email:

BACKGROUND INFORMATION

DOB: | Place of Birth: | Blood Type:

Age: | Gender: | Height: | Weight:

Occupation: | Average Work Hours/Week:

Relationship Status: | Number of Children:

HOBBIES & ACTIVITIES

INITIAL INTERVIEW

GOALS & HEALTH CONCERNS

What are your top 3-5 health concerns?

What would you like to gain from Nutritional Therapy? What are your personal health goals?

SLEEP

Do you sleep well? Yes: ☐ No: ☐

Do you wake up during the night? Yes: ☐ No: ☐ If yes, at what time?

What time do you usually go to bed? What time do you usually wake up?

How do you feel when you wake up?

FOOD & DRINK

How much pure water do you drink per day? (add amount & circle "fl. oz." or "mL") fl. oz. / mL

Do you drink caffeinated drinks (e.g. coffee, black tea, soda, etc.)? Yes: ☐ No: ☐

If yes, how much per day on average? (add amount & circle "fl. oz." or "mL") fl. oz. / mL

What were your eating habits like as a child? (list typical types of food below)

INITIAL INTERVIEW

What % of your food is home cooked? ____ % How many days/week do you typically eat out? ____

What kind of cookware do you usually use (e.g. cast iron, Teflon, aluminum)? ____

What kind of fats do you usually cook with (butter, olive oil, canola, etc.)? ____

In your opinion, what do you think are the three *least healthy* foods you eat each week and why?

Conversely, what do you think are the three *healthiest* foods you eat each week and why?

DIGESTION & APPETITE

Do you often feel tired after meals? Yes: ☐ No: ☐

Do you often feel bloated after meals? Yes: ☐ No: ☐

Do you often feel gassy after meals? Yes: ☐ No: ☐

Do you experience constipation often? Yes: ☐ No: ☐ If yes, how many days/week? ____

Do you experience diarrhea often? Yes: ☐ No: ☐ If yes, how many days/week? ____

Do you often feel excessively hungry? Yes: ☐ No: ☐

Do you often have little or no appetite? Yes: ☐ No: ☐

Do you often crave sugar? Yes: ☐ No: ☐

Do you often crave salt? Yes: ☐ No: ☐

BIRTH & INFANCY

Were you born vaginally or by Cesarean Section? Vaginally: ☐ Cesarean Section: ☐

Were you breastfed as a baby? Yes: ☐ No: ☐ If yes, until what age? ____

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SMOKING & TOXIC EXPOSURE

Do you smoke? Yes: ☐ No: ☐

If so, how many cigarettes per day on average? /day

Are you regularly exposed to secondhand smoke? Yes: ☐ No: ☐

If so, how many days per week on average? /day

Do you have amalgam fillings? Yes: ☐ No: ☐

Have you had amalgam fillings removed or replaced? Yes: ☐ No: ☐

Have you been exposed to toxic substances at work or home? Yes: ☐ No: ☐

If so, what toxins were you exposed to?

MOVEMENT & RELAXATION

Do you enjoy playing sports or being active outside? Yes: ☐ No: ☐

If yes, what are your favorite sports or activities?

On average, how many days a week do you walk? /days

On average, how many days a week do you run? /days

On average, how many days a week do you do high-intensity interval training? /days

On average, how many days a week do you lift weights? /days

On average, how many days a week do you do cardio, aerobics, etc.? /days

On average, how many days a week do you stretch or do yoga? /days

On average, how many hours a day are you sitting? /hours

On average, what is your daily screen time (TV, computer, smartphone, etc.)? /hours

On average, how many days per week do you meditate? /days

On a scale of 1-10 (1 being low and 10 being high), what is your average stress level?

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SUPPLEMENTS, HERBS & MEDICATIONS

Are you currently taking any vitamins, minerals, herbs, homeopathic remedies, prescription or non-prescription medications, aspirin, laxatives, diet pills, or any other supplements? Yes: ☐ No: ☐

If yes, please list all of these below including specific product names and dosages/amounts:

Do you have any known allergies to medications or herbs? Yes: ☐ No: ☐

If yes, please list all known allergies below:

MEDICAL HISTORY

Are you currently under a practitioner's care for a specific issue? Yes: ☐ No: ☐

If so, what treatments are you undergoing?

What is your doctor or practitioner's name and contact information?

Name: Licensure:

Address:

City: State: Zip:

Phone: Type (Cell, Home, Work):

Email:

Have you ever been seriously injured, hospitalized, or suffered from a disease? Yes: ☐ No: ☐

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If so, please list all accidents, injuries, diagnoses, surgeries, etc. you have had below, including the date of the event or diagnosis:

FAMILY HEALTH HISTORY

Please check all conditions below that apply to your parents and grandparents:

Diabetes:	☐	Heart Disease:	☐	Stomach/Intestinal Disorders:	☐
Asthma:	☐	Arthritis:	☐	Gallbladder Disease:	☐
Kidney Disease:	☐	Cancer:	☐	Type of Cancer:	

If not listed above, please write in the condition(s) below:

Please list the ages of your parents and grandparents. If a family member is deceased, please write their age of death and cause (if known).

Mother's Age:		Cause of Death (if Deceased)	
Father's Age:		Cause of Death (if Deceased)	
Maternal Grandmother's Age:		Cause of Death (if Deceased)	
Paternal Grandmother's Age:		Cause of Death (if Deceased)	
Maternal Grandfather's Age:		Cause of Death (if Deceased)	
Paternal Grandfather's Age:		Cause of Death (if Deceased)	

INITIAL INTERVIEW

WOMEN ONLY

Do you feel your libido is adequate? Yes: ☐ No: ☐

Are your periods regular? Yes: ☐ No: ☐ Age of your first period: ☐

How frequent are your periods on average? ☐ /days

How many days is your flow on average? ☐ /days

On average, how heavy is your flow? (Light, Medium, or Heavy) ☐

Do you experience cramps? Yes: ☐ No: ☐ If so, how severe? (Mild, Moderate, or Severe) ☐

Do you experience PMS? Yes: ☐ No: ☐ If so, how severe? (Mild, Moderate, or Severe) ☐

Are you currently pregnant or could you be pregnant? Yes: ☐ No: ☐ If so, how many months? ☐ /months

How many children have you delivered? ☐

Were there any birth complications? Yes: ☐ No: ☐ If so, please elaborate below:

Did you receive antibiotics during labor? Yes: ☐ No: ☐

Have you ever had a miscarriage? Yes: ☐ No: ☐ If so, how many? ☐

Have you undergone fertility treatments? Yes: ☐ No: ☐ If so, what kind? ☐

Are you perimenopausal? Yes: ☐ No: ☐ If so, when did changes begin? ☐

Are you menopausal? Yes: ☐ No: ☐ If so, when was your last period? ☐

If you are perimenopausal or menopausal, please list your symptoms below:

INITIAL INTERVIEW

MEN ONLY

Approximate age of onset of puberty: ☐

Number of children: ☐

Do you feel your libido is adequate?	Yes: ☐	No: ☐
Do you often wake at night to urinate?	Yes: ☐	No: ☐
If yes, how many times per night on average?		☐
Do you have any difficulty or pain with urination?	Yes: ☐	No: ☐
Do you have diminished volume or flow?	Yes: ☐	No: ☐
Have you lost interest in activities you used to greatly enjoy? (e.g. sports, hobbies, etc.)	Yes: ☐	No: ☐
Do you often feel more agitated or irritable than you used to?	Yes: ☐	No: ☐
Do you often feel less assertive in daily life than you used to?	Yes: ☐	No: ☐

NOTES