



Pulling Down the Moon Nutrition Intake

In preparation for your nutrition sessions at Pulling Down the Moon, please complete the following intake form and Quick Symptom Questionnaire and bring them with you to your initial consultation. **In addition, please bring any dietary supplements you are currently taking to your appointment so your nutritionist can accurately assess your current nutritional intake.**

Date ____/____/____

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Gender: _____ Age: _____ Height: _____ Weight: _____ Marital Status: _____ Number of Children: _____

Home Phone _____ Cell/Work Phone _____ Email _____

Occupation _____ Employer _____

Work Address _____

Emergency Contact _____ Phone _____ Cell _____

How did you hear about us? (doctor, nurse, office staff, flyer, postcard, website, friend) _____

Physician name and phone: _____

Reproductive Endocrinologist name and phone: _____

What is your primary reason(s) for seeking nutrition counseling? Please describe current condition.

Please list all medications (and dosages if possible) that you are currently taking or have taken in the past 2 months (vitamins, supplements, over-the-counter medications, herbs)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Family History (M= Mother, F= Father, G= Grandparents, B= Brother, S= Sister, C= Children, Sp= Spouse)

Allergies Arthritis Cancer Diabetes Reproductive Disorders
 Thyroid Disease Alcoholism Heart Disease Stroke Autoimmune Disease

General Medical History Please indicate if you currently have or have had in the past any of the following symptoms or diagnoses:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Gas/bloating | <input type="checkbox"/> Fatigue, sluggishness | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Antibiotic use (extended) | <input type="checkbox"/> Acne breakouts |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Yeast Infections | <input type="checkbox"/> Facial hair growth |
| <input type="checkbox"/> Feel hot often | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hair loss/thinning |
| <input type="checkbox"/> Feel cold often | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Period cramps | <input type="checkbox"/> STD |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Less than 1 bowel movement per day | <input type="checkbox"/> Leg/muscle cramps | <input type="checkbox"/> Other, list: |
| <input type="checkbox"/> Dry hair | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Menstrual clotting | |
| <input type="checkbox"/> Hypothyroid | | <input type="checkbox"/> Irritable/depressed during menses | |

REPRODUCTIVE HISTORY

Regular menses cycle? Yes ___ No ___

Clots? Yes ___ No ___

Pain or Cramping? Yes ___ No ___

Flow is Heavy ___ Medium ___ Light ___

Abnormal Discharge? Yes ___ No ___

Date of last period _____

Number of pregnancies: _____

Number of births: _____

Have you ever been on the birth control pill or any other form of hormonal contraception? _____

If yes, what type? _____ For how long? _____

How long have you been trying to conceive? _____

Have you sought ART previously? _____ If yes, what have you done? _____

If you have gone through in-vitro, how many eggs were retrieved and how many fertilized? _____

Has your partner been tested for any fertility-related problems? _____ If yes, what were the results?

NUTRITION INFORMATION

On a scale of 1-10 (10 being extremely healthful), how do you rate your diet? _____ / 10

Please describe any current dietary restrictions that you may have: _____
_____Do you have food allergies? _____ If so, please describe: _____
_____Have you made any recent changes to your diet? Y N If so, describe these changes: _____
_____**How many of each do you eat per week (please specify):**

_____ fresh vegetables

_____ whole grains

_____ butter

_____ fresh fruit

_____ beans/legumes

_____ margarine

_____ eggs

_____ nuts & seeds

_____ olive oil

_____ chicken/turkey

_____ nut butters

_____ sugar substitute

_____ fish

_____ cheese

_____ tofu/soy

_____ red meat

_____ yogurt

_____ sweets (dessert, candy, cookies)

_____ pork/ham/bacon

_____ milk

_____ refined carbohydrates (crackers, chips, pasta)

Any foods that are not listed that are consumed regularly _____

How many glasses of each do you drink per day:

_____ caffeinated coffee

_____ herbal tea

_____ water

_____ decaffeinated coffee

_____ regular soft drinks

_____ fruit juice

_____ regular tea (black)

_____ diet soft drinks

_____ sports drinks

_____ green tea

_____ diet drinks/aids

_____ alcohol

Any beverages that are not listed that are consumed regularly _____

What is your drinking water source? Tap Bottled Filtered Reverse Osmosis Distilled Well**How often do you choose organic fruits and vegetables and grass-fed/cage-free animal products?** _____**What foods do you crave?** _____

What foods do you avoid? Why? _____

Do you snack during the day? _____ Describe: _____

How many times per week do you eat breakfast? _____ Please describe your usual breakfast: _____

How many times per week do you eat the following at home? away from home?

Breakfast ___/___ Lunch ___/___ Dinner ___/___

Do you generally cook your own meals? _____ How often? _____ Do you like to cook? _____

Where do you do most of your grocery shopping? _____

How would you describe most meals: relaxed rushed seated at the table standing up in front of the TV
in the car alone with family or friends

Do you feel you eat a wide variety of foods? Y N Unsure

How often do you consume sugar? Daily 3-4 times per week Occasionally Seldom/Never

Please comment on your relationship with food: Circle all that apply to you.

fast food prepared meals at home fresh canned frozen boxed or bagged
organic conventional free-range/grass-fed

Do you have good energy levels? Y N Inconsistent

Does napping help or make it worse? _____

Can you attribute low energy to anything in particular? _____

Do you consider yourself: Underweight Overweight Just Right

Please circle:

I **have** / **have not** previously used diet or exercise to lose or gain weight.

I **have** / **have not** previously used medications or supplements to lose or gain weight.

Do you diet frequently? _____ Are you currently on a diet? _____

Do you, or have you ever, used tobacco? Y N # per day _____ # of years _____ If quit, when? _____

Do you drink alcohol? Y N (# per day/week) Beer _____ Wine _____ Liquor _____ If quit, when? _____

SLEEP

What time do you normally go to bed? _____ Fall asleep? _____ Awaken for the day? _____

How many hours of sleep do you need to feel rested? _____ How many hours of sleep do you get? _____

EXERCISE

Do you exercise? Y N If so, how often? Daily Every other day Twice per week Once per week Rarely/Never

What type of exercise do you do?

Walk Aerobics Dance Run Bicycle Team Sports Yoga Weight Lift Other

EMOTIONAL STATE

Rate your current daily stress level (0-10) in regards to:

Job or school _____ Divorce/Separation/Death _____
Primary relationship _____ Family/Parents/Children _____
Financial _____ Other _____

What activities do you engage in to counterbalance stress in your life? _____

Please give any other insights and/or information that you feel might be helpful in your health maintenance: _____

As it is always helpful for our Nutritionists to have ample time to review their patients' pertinent information, Pulling Down the Moon requests (if possible) all patients send in their paperwork at least one day prior to their scheduled appointment. You can send your paperwork to us by scanning and emailing it to info@pullingdownthemoon.com or by faxing it to the applicable location (fax numbers and locations are available on our website www.pullingdownthemoon.com).

Symptom Questionnaire*

(*Adapted from Julia Ross's book "The Diet Cure")

This questionnaire is a quick way to assess many potential root causes of clinical conditions. We use this questionnaire as a springboard to develop a personalized nutrition program and, upon follow-up, to assess improvement.

Hormones

_____ Total Score

- 4 Premenstrual mood swings
- 4 Premenstrual or menopausal food cravings
- 4 Irregular periods or migraines
- 3 Experienced miscarriage, abortion or infertility
- 4 Use(d) birth control pills or other hormone medication
- 3 Uncomfortable periods – cramps, lengthy or heavy bleeding, or sore breasts
- 4 Peri- or postmenopausal discomfort (hot flashed, weight gain, sweats, insomnia or mental dullness)
- 3 Skin eruptions with period

If your score is over 6, your hormones may be out of balance and may need a nutritional program that incorporates working with your doctor.

Blood Sugar and Stress

_____ Total Score

- 4 Crave a lift from sweets or alcohol, but experience a drop in mood afterwards
- 4 Family history of diabetes, hypoglycemia or alcoholism
- 3 Nervous, jittery, irritable, headachy or work, on and off during the day. Calmer after meals.
- 3 Frequent infections, allergies or asthma, especially when the weather changes
- 3 Mental confusion, decreased memory, hard to focus or get organized
- 4 Frequent thirst
- 3 Night sweats (not due to menopause)
- 5 Light-headed, especially on standing up
- 4 Crave salty foods or licorice
- 4 Often feel stressed, overwhelmed and exhausted
- 4 Dark circles under eyes or eyes sensitive to bright light
- 4 More awake at night

If your score is over 12, it's important that you work on balancing blood sugar and controlling your stress levels.

Thyroid Function

_____ Total Score

- 4 Low energy
- 4 Easily chilled (especially hands and feet)
- 4 Other family members have thyroid problems

- 4 Can gain weight without overeating; hard to lose excess weight
- 3 Have to force yourself to do even moderate exercise
- 4 Find it hard to get going in the morning
- 3 High cholesterol
- 3 Low blood pressure
- 4 Weight gain began near the start of menses, a pregnancy or menopause
- 3 Chronic headaches
- 3 Use food, caffeine, tobacco and/or other stimulants to get going

If your score is over 15, you may need to get your thyroid checked. Your nutritionist can show you ways to support your thyroid, for more energy, naturally.

Food Allergies

_____ **Total Score**

- 3 Crave milk, ice cream, yogurt, cheese or doughy foods and eat them frequently
- 3 Experience bloating after meals
- 4 Gas, frequent belching
- 3 Digestive discomfort of any kind
- 3 Chronic constipation and/or diarrhea
- 4 Respiratory problems, such as asthma, postnasal drip, congestion
- 3 Low energy or drowsiness, especially after meals
- 4 Allergic to milk products or other common foods
- 3 Under-eat or often prefer beverages to solid foods
- 3 Avoid food or throw up food because bloating after eating makes you feel fat or tired
- 4 Can't gain weight
- 3 Hyperactivity or depression
- 3 Severe headaches or migraine
- 4 Food allergies in the family

If your score is over 12, you may be craving foods you are allergic to. Elimination diets can pinpoint the offending foods, and elimination of them usually results in weight loss and increased energy.

Yeast

_____ **Total Score**

- 4 Often bloated; abdominal extension
- 3 Foggy-headed
- 2 Depressed
- 4 Yeast infections
- 4 Used antibiotics extensively (any point in life)
- 4 Used cortisone or birth controls for more than one year
- 4 Have chronic fungus on nails or skin or athlete's foot
- 3 Recurring sinus or ear infections as an adult or child
- 3 Achy muscles and joints
- 4 Rashes
- 3 Stool unusual in color, shape or consistency

If you scored over 12, you have a yeast problem which your nutritionist can address with dietary changes and natural nutritional therapies.

Brain Chemistry

_____ **Total Score**

- 4 Sensitivity to emotion (or physical) pain, cry easily
- 4 Eat as a reward, for pleasure, comfort or numbness
- 4 Worry, anxiety, phobia or panic
- 4 Difficulty getting to sleep or staying asleep
- 3 Difficulty with focus, attention deficits
- 2 Low energy, drive and arousal
- 4 Obsessive thinking or behavior
- 4 Inability to relax after tension/stress
- 3 Depression, negativity
- 4 Low self esteem, lack of confidence
- 4 More mood and eating problems in winter or end of day
- 3 Irritability, anger
- 4 Use alcohol or drugs to improve mood

If your score is over 10, your brain chemistry and neurotransmitters may be out of balance. A nutritionist can help you improve your brain chemistry naturally.

Low Calorie Dieting

_____ **Total Score**

- 4 Increased cravings for and focus on food, overeating
- 4 Regain weight after dieting, more than was lost
- 3 Increased moodiness, irritability, anxiety or depression
- 3 Less energy and endurance
- 3 Usually eat less than 2,100 calories/day
- 3 Skip meals, especially breakfast
- 3 Eat mostly low-fat carbs like bagels and pasta
- 2 Constantly think about weight
- 2 Use aspartame daily
- 2 Take Prozac or similar serotonin-boosting drugs
- 2 Have become vegetarian
- 3 Decreased self-esteem
- 4 Have become bulimic or anorectic

If your score is over 12, your body may not be burning calories as fast as it could due to low calorie intake. You may also be deficient in critical nutrients. Through counseling, a nutritionist will help educate you on why it's important NOT to deprive yourself of food.