



## Nutrition Intake Form

(please print)

\_\_\_\_\_  
First & Last Name Today's Date

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Phone Number Email Address Ht Wt Sex Age Date of Birth

\_\_\_\_\_  
Your Occupation/Employer Emergency Contact (Name & Phone Number)

\_\_\_\_\_  
Primary Care Physician (Name, Practice, Location)

\_\_\_\_\_  
OB/GYN or Urologist (Name, Practice, Location)

\_\_\_\_\_  
Reproductive Endocrinologist (Name, Practice, Location)

\_\_\_\_\_  
How did you hear about us? (doctor, nurse, friend, website, flyer)

In case of a Press Event, would you be willing to share your story?  Yes  No

If YES, please check which of the following we could contact you about:

- Print/Interview  TV  Radio  Testimonial

### Health History

\_\_\_\_\_  
What are the health problems for which you are seeking treatment?

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
How long have you had this condition?

\_\_\_\_\_  
What other forms of treatment have you sought?

\_\_\_\_\_  
Please list any surgeries or major health incidents (year and type)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Family Medical History

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

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 _____ | 5 _____ |
| 2 _____ | 6 _____ |
| 3 _____ | 7 _____ |
| 4 _____ | 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

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

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

## Reproductive History

Regular menses cycle?  Yes  No    Date of last period \_\_\_\_\_    Clots?  Yes  No  
Pain or Cramping?  Yes  No    Flow is  Heavy  Medium  Light    Abnormal Discharge?  Yes  No  
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?  Yes  No    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?  Yes  No  
If yes, what were the results? \_\_\_\_\_

## Nutrition Information

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

Please describe any current dietary restrictions that you may have \_\_\_\_\_

Do you have food allergies?  Yes  No If yes, please describe \_\_\_\_\_

Have you made any recent changes to your diet?  Yes  No If yes, please describe \_\_\_\_\_

Please specify how many of the follow you eat *per week*:

_____ beans/legumes	_____ fresh vegetables	_____ red meat
_____ butter	_____ margarine	_____ refined carbs (crackers, chips, pasta)
_____ cheese	_____ milk	_____ sugar substitute
_____ chicken/turkey	_____ nut butters	_____ sweets (dessert, candy, cookies)
_____ eggs	_____ nuts & seeds	_____ tofu/soy
_____ fish	_____ olive oil	_____ whole grains
_____ fresh fruit	_____ pork/ham/bacon	_____ yogurt

Please indicate any foods that are not listed that you consume regularly \_\_\_\_\_

Please specify how many of the follow you drink *per week*:

_____ alcohol	_____ diet soft drinks	_____ regular soft drinks
_____ caffeinated coffee	_____ fruit juice	_____ regular tea (black)
_____ decaf coffee	_____ green tea	_____ sports drinks
_____ diet drinks/aids	_____ herbal tea	_____ water

Please indicate any beverages that are not listed that you consume 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?  Yes  No If yeas, please describe \_\_\_\_\_

How many times per week do you eat breakfast? \_\_\_\_\_ Please describe your usual breakfast \_\_\_\_\_

Please specify how many times you eat the following meals away from home *per week*:

\_\_\_\_\_ Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner

Do you generally cook your own meals? \_\_\_\_\_ How often? \_\_\_\_\_ Do you like to cook?  Yes  No

Where do you do most of your grocery shopping? \_\_\_\_\_

How would you describe most meals:  Relaxed  Rushed  Standing up in front of the TV

Seated at the table  In the car  Alone  With family or friends

Do you feel you eat a wide variety of foods?  Yes  No  Unsure

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

Please specify which of the following are included in your diet:  Fast Food  Prepared Meals at Home  Fresh

Canned  Frozen  Boxed or Bagged  Organic  Conventional  Free-Range/Grass-Fed

Do you have good energy levels?  Yes  No  Inconsistent Does napping help or make it worse?  Yes  No

Can you attribute low energy to anything in particular?  Yes  No

If yes, please specify \_\_\_\_\_

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?  Yes  No Are you currently on a diet?  Yes  No

Do you, or have you ever used tobacco?  Yes  No \_\_\_\_\_ # per day \_\_\_\_\_ # of years if quit, when? \_\_\_\_\_

Do you drink alcohol?  Yes  No (# per day/week) Beer \_\_\_\_/\_\_\_\_ Wine \_\_\_\_/\_\_\_\_ Liquor \_\_\_\_/\_\_\_\_

If quit, when? \_\_\_\_\_

**Sleep** Time you normally go to bed \_\_\_\_\_ Fall asleep \_\_\_\_\_ Awaken for the day \_\_\_\_\_

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

**Exercise** Do you exercise?  Yes  No

If so, how often?  Daily  Every other day  Twice per week  Once per week  Rarely

Type of exercise?  Walk  Aerobics  Dance  Run  Bicycle  Team Sports  Yoga  Weight Lift

Other, please specify \_\_\_\_\_

**Emotional State** Rate your current daily stress level (0-10) in regard to: \_\_\_\_\_ Job or school \_\_\_\_\_

Divorce/Separation/Death \_\_\_\_\_ Primary relationship \_\_\_\_\_ Family/Parents/Children \_\_\_\_\_ Financial

\_\_\_\_\_ Other, please specify \_\_\_\_\_

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

Please provide any additional information you feel might be helpful \_\_\_\_\_

\*\*\*It is helpful for our Nutritionists to have ample time to review your information. If possible, please send your paperwork at least one day prior to your scheduled appointment. You can send your paperwork to us by scanning and emailing it to [info@pullingdownthemoon.com](mailto:info@pullingdownthemoon.com) or by faxing it to the applicable location (fax numbers and locations are available on our website [www.pullingdownthemoon.com](http://www.pullingdownthemoon.com)). Thank you

## 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 it 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 & 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.*