Initial Nutrition Visit Form

Name____ Date_________________________

Address____

City___________________________ State_______ Zip__________ Phone _____________________

Email____ Date of Birth____________________________

Referred By: ____Internet ____ Friend, Relative, or Co-Worker ____Other (Let us know who/how!) _______

Please list any medications/supplements you are currently using and when you began taking them:

____

WHAT MAIN HEALTH ISSUES DO YOU NEED HELP WITH?
CHECK/RATE ALL THAT APPLY TO YOU

___ Low Energy, Fatigue

___ Weight

___ Pain

___ Headaches

___ Difficulty Walking or Moving

___ Blood Pressure Mgt.

___ Blood Sugar Mgt.

___ Cholesterol Mgt.

___ Asthma, Breathing Difficulty

___ Allergies, Sinus, Respiratory

___ Frequent Urination/Bladder Leakage

___ Skin Rashes or Breakouts

___ Itching or Burning Anywhere

___ Heart Racing or Palpitations

___ Frequent Colds, Flu or Infections

___ Sleeping Difficulty

___ Mood Swings

___ Anxiety/Nervousness

___Depression

___ Dizziness, Vertigo

___ Focus/Concentration/Memory

___ Cold Hands/Feet

___ Hot Flashes/Night Sweats

___PMS or Period Problems

___ Infertility/Pregnancy Challenges

___ Learning Difficulty/Hyperactivity

___ Erectile or Prostate Difficulty

___ Diarrhea ___ Constipation ___Gas

___ Bloating ___Heartburn ___Nausea

___Other not listed? ________________________

What is Your Main Health Concern?

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