Health History Forms

Before you begin filling out these Health History Forms:

- Save this file to your computer (file ⇨ save as ⇨ save to your desktop). Close the browser window after saving.
- Find the file on your desktop ⇨ Right-click ⇨ Open with... ⇨ Adobe Reader to either 1) fill out the forms electronically or 2) print the forms and fill them out by hand.
- **ATTN MAC USERS:** do not use "Preview" to fill out these forms. Use Adobe Reader, otherwise your information will not save properly. Print the forms and complete them by hand if you cannot use Adobe Reader.
- **ATTN PC USERS:** do not use "Windows Image and Fax Viewer" to fill out these forms. Use Adobe Reader, otherwise your information will not save properly. Print the forms and complete them by hand if you cannot use Adobe Reader.

Thank you for choosing Nutritional Weight & Wellness for your nutrition consultation!

Every day we see nutrition improve the lives of our clients, and we look forward to seeing what nutrition can do for you.

Your initial nutrition consultation will last approximately two hours.

Prior to your appointment — Complete the enclosed Health History Forms

This can be done two ways:

1. **You may fill them out electronically in Adobe Reader.** Make sure you open the forms in Adobe Reader *(NOTE: your information will not save properly if you do not use this application. If you choose not to use this Adobe Reader, do not complete the forms electronically. Instead, print them and fill in your information by hand)*. As you fill in your personal information, save often while you're working and also when you are finished with the forms to ensure all of your data is captured.
2. You may print the forms and **fill them out by hand.**

Submit your completed Health History Forms to Nutritional Weight & Wellness:

- **E-mail** your forms to *romaine@weightandwellness.com*,
- **Fax** them to 651-695-0191, or
- **Mail*** them to our St. Paul office: 708 S. Cleveland Ave, St. Paul, MN 55116

**This must be done 5-7 days prior to your appointment so we receive your forms in time.*

On the day of your appointment

1. Please arrive at least five minutes prior to the scheduled time of your appointment.
2. Bring any prescription medications or supplements you are currently taking, as well as any lab results you would like to discuss.
3. Please refrain from wearing perfume or cologne as many of our clients are sensitive to scents.
4. Please note that payment is due in full at the time of your appointment.

Some insurance companies will reimburse you for nutrition counseling If you would like to submit a claim to your insurance company, contact the member services department of your insurance provider to check coverage. Nutritional Weight & Wellness is considered an out-of-network provider. If you choose to submit a claim, we will provide the necessary information at the time of your visit.

If for any reason you must call and cancel this appointment or future appointments, please give 24-hour advanced notice.

If you have any questions, please call 651-699-3438 or toll free (800) 805-8954

Nutritional Weight & Wellness
educating and counseling people to better health

Offices in St. Paul, Wayzata, North Oaks, Lakeville and Maple Grove | 651-699-3438 | weightandwellness.com

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Infant/Child Nutrition Questionnaire

Name_____ Date: _____DOB: _____
Address _____ City _____ State/Zip _____
Phone: (H) _____ (C) _____ Email: _____
Age: _____ Height: _____ Weight:_____ Parent(s) Name(s): _____
Reason and goals for consultation:_____
_____

For follow-up, which is the best way to reach you? Phone ○ Email ○

Health History

Please check any that apply to your child (past or present)

	Past	Present		Past	Present		Past	Present
Acne	☐	☐	Depression	☐	☐	Juvenile Rheumatoid Arthritis	☐	☐
ADD/ADHD	☐	☐	Diabetes I (insulin dependant)	☐	☐	Liver problems	☐	☐
Addiction (alcohol, drugs)	☐	☐	Diarrhea	☐	☐	Loose stools	☐	☐
Allergies	☐	☐	Difficulty losing weight	☐	☐	Memory loss or confusion	☐	☐
Anemia	☐	☐	Difficulty gaining weight	☐	☐	Nails, poor growth	☐	☐
Anorexia/bulimia	☐	☐	Ear Infections	☐	☐	Nails, white spots	☐	☐
Anxiety or nervousness	☐	☐	Eczema	☐	☐	Panic attacks	☐	☐
Asthma	☐	☐	Emotional problems	☐	☐	Parasites	☐	☐
Bed wetting	☐	☐	(instability or sensitivity)			Pneumonia	☐	☐
Bladder infections (Cystitis)	☐	☐	Fainting	☐	☐	Psoriasis	☐	☐
Bloating, gas	☐	☐	Gall bladder problems	☐	☐	Respiratory problems	☐	☐
Blood sugar problems	☐	☐	Poor hair growth	☐	☐	Ringing in ears	☐	☐
Bronchitis	☐	☐	Headaches	☐	☐	Seizures	☐	☐
Cancer	☐	☐	Heart condition	☐	☐	Severe mood swings	☐	☐
Celiac disease	☐	☐	Heartburn	☐	☐	Skin conditions	☐	☐
Colds or flu (frequent)	☐	☐	HIV	☐	☐	Stomach aches	☐	☐
Cold sores	☐	☐	Hot flashes	☐	☐	Suicidal tendencies	☐	☐
Chronic fatigue	☐	☐	Hypoglycemia	☐	☐	Thyroid condition	☐	☐
Constipation	☐	☐	Insomnia	☐	☐	Yeast infections	☐	☐
Cradle cap	☐	☐	Intestinal problems	☐	☐			

Describe concentration, activity level, and behavior: _____
_____
List any behavoir issues: _____
_____

Diet Review

Describe a typical day's meals for your child (including snacks, drinks, time of each). Be as specific as you can.

Breakfast: _____

_____

_____ Usual time: _____

Lunch: _____

_____

_____ Usual time: _____

Dinner: _____

_____

_____ Usual time: _____

Snacks: _____

_____

_____ Usual time(s): _____

How many times does your child usually eat per day? _____

How many 8 oz. glasses of water does your child drink per day? _____

Does your child drink:

- ☐ soda — How many 8 oz. per day? _____
- ☐ tea — How many 8 oz. per day? What type? _____
- ☐ fruit juice — How many 8 oz. per day? _____
- ☐ milk — How many 8 oz. per day? _____

Does he/she get noticeably irritable, light-headed, or weak if you haven't eaten in a while? _____

Does he/she often skip meals? _____ If yes, which does he/she most commonly skip? _____

What times(s) of the day is your child most hungry? _____

Does he/she crave:

☐ sugar	☐ meat	☐ fat
☐ chocolate	☐ fish	☐ alcohol
☐ desserts	☐ milk	☐ bread
☐ fried foods	☐ other _____	

Which oils does he/she consume:

☐ butter	☐ peanut oil	☐ canola oil
☐ margarine	☐ corn oil	☐ sunflower/safflower oil
☐ olive oil	☐ Crisco	☐ mayonnaise
☐ coconut oil	☐ vegetable oil	☐ flaxseed oil
☐ soybean oil	☐ other _____	

What are his/her favorite foods? _____

_____

What foods does he/she strongly dislike? _____

_____

Is your child currently under a physician's care for a chronic health problem that requires continuous monitoring?
If yes, please explain. _____

_____

_____

Please list any medications your child is currently taking: _____

_____

_____

Does your child take any nutritional supplements or vitamins? Please list if yes (attach list if necessary).

_____

_____

Please list any disease, illness, or ailments in your child's immediate family (i.e. mother, father, grandparents).

_____

_____

Please feel free to expand on any concerns you feel are relevant to your child's health.

_____

_____

_____

Does your child have any food allergies, restrictions or sensitivities? _____

_____

_____

Lifestyle Factors

Do you exercise?_____ If so, what kind? _____

Frequency? _____

Please rate the following:

Daily energy level:	**Daily stress level:**	**Energy after exercise:**	**General enjoyment of life:**
☐ Excellent	☐ Very high	☐ Excellent	☐ Excellent
☐ Good	☐ High	☐ Good	☐ Good
☐ Fair	☐ Moderate	☐ Fair	☐ Fair
☐ Poor	☐ Low	☐ Poor	☐ Poor
	☐ None		

Do you consider your child:	☐ inactive	☐ active	☐ very active
Is your child:	☐ often tired	☐ occasionally tired	☐ rarely tired

Check all that apply:

- ☐ He/She like to interact with others
- ☐ People generally enjoy his/her company
- ☐ He/She has many friends
- ☐ He/She prefers to spend time alone
- ☐ He/She concentrates and completes tasks
- ☐ He/She is distracted easily
- ☐ He/She can only focus on specific tasks

How much sleep does he/she get on average each night? _____

Any problems sleeping? _____

Do you smoke? _____ Have you recently quit smoking? _____

How is his/her dental health? _____

How often does he/she have bowel movements? _____

How often does he/she urinate? _____

Is he/she a:		☐ light eater	☐ moderate eater	☐ heavy eater
Is he/she often hungry? _____ if yes:		☐ when they wake up	☐ late morning	☐ mid afternoon
	☐ all day long	☐ end of the day	☐ before going to bed	☐ all night

How often does your family eat out? _____

What restaurants? _____

Infant/Child Health Survey

Rate each of the following symptoms based upon your health profile for the past 6 months:

POINT SCALE: 0 = **Never** or **Almost Never** have the symptoms
1 = **Occasionally** have it, effect is **Not Severe**
2 = **Occasionally** have it, effect is **Severe**
3 = **Frequently** have it, effect is **Not Severe**
4 = **Frequently** have it, effect is **Severe**

Digestive
_____ Nausea or vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Reflux
__0__ TOTAL

Ears
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears
_____ Hearing loss
__0__ TOTAL

Emotions
_____ Mood swings, tantrums
_____ Fearful
_____ Irritable, demanding
_____ Depression
_____ Acting out, aggressive
__0__ TOTAL

Low Energy
_____ Sluggishness, low energy
_____ Lack of interest, apathy
_____ Difficulty waking
_____ Can't stay awake in class
_____ Feeling tired or weak
__0__ TOTAL

Excess Energy
_____ Hyperactive
_____ Restless, fidgety
_____ Out of control
__0__ TOTAL

Sleep
_____ Difficulty falling asleep
_____ Difficulty staying asleep
_____ Sleep walking
_____ Nightmares
_____ Bedwetting
__0__ TOTAL

Eyes
_____ Watery, itchy eyes
_____ Swollen, red, or sticky eyelids
_____ Dark circles under eyes
__0__ TOTAL

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Difficulty breathing
__0__ TOTAL

Mind
_____ Headaches
_____ Poor Memory
_____ Confusion
_____ Poor concentration
_____ Poor coordination
_____ Difficulty making decisions
_____ Stuttering, stammering
_____ Slurred speech
_____ Learning problems
__0__ TOTAL

Mouth/Throat
_____ Chronic coughing
_____ Gagging, clears throat frequently
_____ Cavities, tooth decay
_____ Swollen, discolored tongue, gums, or lips
_____ Canker sores
__0__ TOTAL

Nose
_____ Snoring
_____ Stuffy nose
_____ Sinus problems
_____ Sinus Drainage
_____ Sneezing attacks
_____ Excessive mucus
__0__ TOTAL

Heart
_____ Skipped heartbeats
_____ Rapid heartbeats
__0__ TOTAL

Skin
_____ Acne
_____ Hives
_____ Rashes
_____ Dry skin
__0__ TOTAL

Heart
_____ Skipped heartbeats
_____ Rapid heartbeats
__0__ TOTAL

Joints/Muscles
_____ Pain or aches in joints
_____ Juvenile arthritis
_____ Stiffness, limited movement
_____ Cramps, aches in muscles
__0__ TOTAL

Weight
_____ Binge eating or drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Underweight
_____ Pre-diabetic/diabetic
__0__ TOTAL

Other
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch, discharge
__0__ TOTAL

__0__ **Grand Total**

Add up the numbers to arrive at a total for each section to arrive at the grand total.

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Nutrition Counseling Waiver and Release of Liability

I agree and understand that during and after participating in nutrition counseling from Nutritional Weight & Wellness, Inc.:

_____ 1. I authorize Nutritional Weight & Wellness Inc. to keep and secure files related to my nutrition counseling sessions at its offices.

_____ 2. I understand that Nutritional Weight & Wellness Inc. provides no guarantee or assurances that through nutrition counseling I will achieve my wellness goals, lose weight, or overcome or avoid health issues, such as cardiovascular disease or diabetes.

_____ 3. I assume all responsibility and any risks associated with the nutritional choices that I make. I agree to hold Nutritional Weight & Wellness, Inc. and its counselors harmless and release them from any liabilities associated with recommendations and information given by them to me relating to dietary changes or nutritional supplements. I specifically recognize and agree that I have been advised by Nutritional Weight & Wellness, Inc. that dietary changes and/or the taking of nutritional supplements may have differing effects on individuals. I understand that with respect to changes in my diet or in my nutritional practices it is recommended that I consult with my physician.

_____ 4. I understand that the nutritional counseling provided is not considered to be medical advice and that I am encouraged to continue to pursue medical care with my health care provider.

Having read and understood the above release and having had the opportunity to ask questions regarding the meaning and effect of this Waiver and Release of Liability, my signing is voluntary.

_____ _____
Date Signature of Parent or Guardian

_____
Printed Name of Parent or Guardian