Emerald Aspire

Nutrition and **Lifestyle** Intake Form

Welcome! Please complete this form prior to our first meeting if at all possible. It should take 30-45 minutes to complete, and I'll get a notification when you're finished. You're welcome to skip questions if you're not comfortable answering them.

From your Practice Better dashboard, you should see a food journal and a lifestyle journal. If you're able to log your meals and complete the lifestyle journal for three days prior to our visit, that would be extremely helpful. If not, no worries! I'm looking forward to meeting with you soon. Reach out any time with questions. - Liz

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Client Questionnaire

Personal Information

First name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Relationship status

Occupation

Hours per week

Gender:

Name you wish to be called:

Pronouns:

Racial/Ethnic Background

- ☐ African/African American
- ☐ Native American
- ☐ Hispanic
- ☐ Other
- ☐ Caucasian
- ☐ Asian/Asian American
- ☐ Northern European

Please specify:

Primary Care Provider

Note that I will not contact other providers regarding our work together without your express consent. Providing one or more ways to contact your other providers facilitates this process if you wish for us to be in contact.

Title | First name | Last name

Work phone | Mobile phone | Fax number

Email address

Title/Occupation

Are you working with other practitioners?

This includes specialists and providers such as massage therapists, acupuncturists, therapists/counselors, etc.

○ Yes ○ No

List the other practitioners who support you:

Name	Type of practitioner	How long?

Goals & Concerns

Why did you decide to schedule an appointment with me?

List your most pressing health concerns or goals:

	Health Concern/Goal	Why is this a concern/goal?	How long has this been going on?
1.			
2.			
3.			

Medical History

Please check health conditions that you've experienced and/or that a provider has diagnosed and provide the date of onset.

Gastrointestinal

	Past	Now	Date of onset/notes
Celiac Disease	☐	☐	
Chronic constipation	☐	☐	
Crohn's Disease	☐	☐	
Diverticulitis/ diverticulosis	☐	☐	
Excessive Gas/Bloating	☐	☐	
Gastric or peptic ulcer	☐	☐	
GERD/heartburn/reflux	☐	☐	
Irritable Bowel Syndrome	☐	☐	
Liver Disease	☐	☐	
Small Intestinal Bacterial Overgrowth (SIBO)	☐	☐	
Ulcerative Colitis	☐	☐	

How often do you have a bowel movement?

Which describe your stools:

- ☐ Well-formed
- ☐ Hard
- ☐ Visible/undigested food
- ☐ May contain blood or mucous
- ☐ Loose
- ☐ Pellets or small pieces
- ☐ Brown
- ☐ May be yellow, green, grey

Do you have difficulty or pain associated with passing bowel movements? ◯ Yes ◯ No

If your bowels are disturbed, do you tend to:

- ☐ Constipation
- ☐ Diarrhoea
- ☐ Both
- ☐ Not sure

Have you ever had a colonoscopy? ◯ Yes ◯ No

Other Gastrointestinal conditions:
Indicate whether past or current & include date of onset.

Respiratory

	Past	Now	Date of onset/notes
Asthma	☐	☐	
Bronchitis	☐	☐	
Chronic Sinusitis	☐	☐	
COPD	☐	☐	
COVID-19	☐	☐	
Emphysema	☐	☐	
Pneumonia	☐	☐	
Sleep Apnea	☐	☐	
Tuberculosis	☐	☐	

Other Respiratory conditions:
Indicate whether past or current & include date of onset.

Musculoskeletal/Pain/Autoimmune

	Past	Now	Date of onset/notes
Chronic Fatigue Syndrome	☐	☐	
Epstein-Barr Virus	☐	☐	
Fibromyalgia	☐	☐	
Graves Disease	☐	☐	
Gout	☐	☐	
Hashimoto's Thyroiditis	☐	☐	
Herpes	☐	☐	
Lupus/SLE	☐	☐	
Lyme Disease	☐	☐	

Migraines	☐	☐	
Non-Migraine Headache	☐	☐	
Osteoarthritis	☐	☐	
Rheumatoid Arthritis	☐	☐	

Other Inflammatory/Autoimmune conditions:
Indicate whether past or current & include date of onset.

Neurological and Mental Health

	Past	Now	Date of onset/notes
ADD/ADHD	☐	☐	
Addiction or Substance Abuse	☐	☐	
Alzheimer's Disease	☐	☐	
ALS	☐	☐	
Anorexia	☐	☐	
Anxiety	☐	☐	
Asperger's/Autism	☐	☐	
Bulimia	☐	☐	
Depression	☐	☐	
Other Eating Disorder	☐	☐	
Parkinson's Disease	☐	☐	
Seizures	☐	☐	
Stroke	☐	☐	
Suicidal thoughts or ideation	☐	☐	

Other Neurological/Mental Health conditions:
Indicate whether past or current & include date of onset.

Blood/Cardiovascular Health

	Past	Now	Date of onset/notes
Anemia	☐	☐	

Atherosclerosis	☐	☐	
Beta-thalassemia	☐	☐	
Elevated Cholesterol	☐	☐	
Heart Attack/MI	☐	☐	
High Blood Pressure	☐	☐	
Irregular Heart Beat	☐	☐	
Low Blood Pressure	☐	☐	
Mitral Valve Prolapse	☐	☐	

What was your blood pressure the last time it was checked?
Include the approximate date if you can recall

Other Cardiovascular conditions
Indicate whether past or current & include date of onset.

Urinary/Gynecological Health

	Past	Now	Date of onset/notes
Endometriosis	☐	☐	
Erectile Dysfunction	☐	☐	
Infertility	☐	☐	
Interstitial Cystitis	☐	☐	
Kidney Stones	☐	☐	
Pregnancy Loss	☐	☐	
Problems with sperm count, motility, morpholgy	☐	☐	
Prostate Problems	☐	☐	
Sexually-Transmitted Infection	☐	☐	
Uterine Fibroids	☐	☐	
Urinary Tract Infection	☐	☐	
Yeast Infection	☐	☐	

Sexual Health

Do you experience any of the following?

- ☐ Low libido
- ☐ Difficulty reaching orgasm
- ☐ Pain with sex
- ☐ Vaginal dryness

Are you currently trying to conceive? ◯ Yes ◯ No

Other Urinary/Gynecological conditions

Indicate whether past or current & include date of onset.

Cancer

	Type	Treatment
Cancer:		

Metabolic/Endocrine

	Past	Now	Date of onset/notes
Diabetes, Type I	☐	☐	
Diabetes, Type II	☐	☐	
Hypoglycemia	☐	☐	
Hypothyroidism/Hashimoto's Thyroiditis	☐	☐	
Hyperthyroidism/Graves' Disease	☐	☐	
Metabolic Syndrome (pre-diabetes, insulin resistance)	☐	☐	
Polycystic Ovarian Syndrome	☐	☐	

Other Metabolic/Endocrine conditions

Indicate whether past or current & include date of onset.

Dermatological

	Past	Now	Date of onset/notes
Acne	☐	☐	
Eczema/Atopic Dermatitis	☐	☐	
Psoriasis	☐	☐	
Rosacea	☐	☐	
Rash	☐	☐	

Other Dermatological conditions

Indicate whether past or current & include date of onset.

Describe any additional medical or health concerns:

Menstruation, Pregnancy, and Lactation History

Is this section relevant for you?
Check yes if you currently menstruate or used to menstruate.

◯ Yes ◯ No

Are you now or have you ever been pregnant?

◯ Yes ◯ No

Pregnancies
Include losses, terminations if you are comfortable doing so

Date	Outcome (vaginal/c-sec, loss, termination)	Notes

Are you currently in your menstrual years?
If you are between puberty and menopause, check yes!

◯ Yes ◯ No

Date of last menstrual period?
Note the first day of heavy bleeding during your last menstrual cycle.

Are you ovulating regularly? How do you know?

How many days pass between your menstrual cycles?
Start from the first day of heavy bleeding and count until the first day of heavy bleeding in the following cycle.

How many days of bleeding do you experience each cycle?
Please also note if you experience bleeding in between cycles and which days.

Do you experience any of the following related to your menstrual cycle?

- ☐ Heavy bleeding/clotting
- ☐ PMS or PMDD
- ☐ Mood changes
- ☐ Irregular or infrequent cycles

- [ ] Spotting
- [ ] Cramping
- [ ] Food cravings
- [ ] Changes in bowel movements

Would you consider your flow on your heaviest day to be:

- ◯ Extremely heavy
- ◯ Heavy
- ◯ Medium
- ◯ Light
- ◯ Very light
- ◯ Not sure

What type(s) of birth control are you using (if relevant)?

Are you currently lactating? ◯ Yes ◯ No

Are you currently peri- or post-menopausal? ◯ Yes ◯ No

Do you experience any of the following symptoms?

- [ ] Hot flashes/night sweats
- [ ] Changes in mood
- [ ] Vaginal dryness
- [ ] Weight gain
- [ ] Cognitive changes (forgetfulness, etc)
- [ ] Hair loss or thinning

Birth History and Childhood Health

Your birth:

- ◯ Vaginal
- ◯ C-Section
- ◯ Unknown

Were you breastfed as an infant?

- ◯ Yes
- ◯ No
- ◯ Don't know

For how long?

How would you rate your health as a child?

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Please describe any health challenges or significant experiences from childhood.

Family History

Please note any history of the following conditions within your biological family: fibroids, endometriosis, miscarriage, stillbirth, clotting disorder, heart disease, cancer, stroke, high blood pressure, lung disease, kidney disease, diabetes, mental illness/addiction, and any other significant illness/condition.

Family History

Family member:	Health condition:	Deceased?
		☐
		☐
		☐
		☐
		☐

Known genetic disorders:

Comments:

Allergy Information

Do you experience any food, environmental, seasonal or other allergies? ◯ Yes ◯ No

Please describe any allergies, including the substances to which you are allergic and any symptoms you experience.

Medications & Supplements

Please list all prescription and over-the-counter medications you use, as well as any nutritional supplements and herbs you are currently taking. Note that the first chart is for medications, and the second is for herbs and supplements.

Prescription and Over-the-Counter Medications

Medication Name	Dosage/Frequency	Reason

Herbs and Nutritional Supplements

Supplement Name (include Brand)	Dosage/Frequency	Reason

Have you had prolonged or regular use of NSAIDs (Aspirin, Advil. Aleve, etc.), ◯ Yes ◯ No

Have you had prolonged or regular use of Tylenol?	◯ Yes	◯ No
Have you had prolonged or regular use of opioid pain killers?	◯ Yes	◯ No
Have you had prolonged or regular use of proton pump inhibitors (PPI) or acid-blocking drugs?	◯ Yes	◯ No
Frequent antibiotoic use? (> 3 times per year)	◯ Yes	◯ No
Long-term antibiotic use?	◯ Yes	◯ No

Surgeries/Hospitalizations

Please list any previous injuries, surgeries, and hospitalizations; provide the date and your age, if known.

Diagnostic Studies/Labs

If you have lab work or other test results that you'd like to share, you can upload them to your "Documents" from the Practice Better dashboard.

Please list any recent lab work or diagnostic studies that you'd like to bring to my attention.
If there are any results that concern you, please note them here.

Nutrition History

Have you ever had a nutrition or herbal consultation? ◯ Yes ◯ No

Have you made any changes to your eating habits because of your health? ◯ Yes ◯ No

Do you currently follow a special diet or nutritional program? ◯ Yes ◯ No

How would you rate the quality of your diet over the past month?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

1 = Poor, 5 = Excellent

How many servings of fruits/vegetables do you currently eat each day?

◯ 8+
◯ 5-7
◯ 3-4
◯ 0-2

Height & Weight

Please feel free to skip any questions about weight if you prefer not to answer them. We will only address weight loss if this is one of your goals.

Height:	
Current weight:	
Usual weight:	
Desired/Goal weight:	
Weight 1 year ago:	

Have you recently lost or gained a significant amount of weight? ◯ Yes ◯ No

Do you have a history of dieting?
In other words, have you repeatedly followed one or more diets for weight loss or health? ◯ Yes ◯ No

What are your comfort foods?

How often do you eat out each week?
Include meals eaten in restaurants and take-out

Do you currently have or are you in recovery from an eating disorder? ◯ Yes ◯ No

What types of beverages do you consume

	Rarely/Never	Weekly	Several times/week	Daily	Several times/day
	◯	◯	◯	◯	◯
Tap or filtered water	◯	◯	◯	◯	◯
Coffee	◯	◯	◯	◯	◯
Caffeinated tea	◯	◯	◯	◯	◯
Soda	◯	◯	◯	◯	◯
Sparkling water	◯	◯	◯	◯	◯
Herbal or noncaffeinated tea	◯	◯	◯	◯	◯
Wine	◯	◯	◯	◯	◯
Beer	◯	◯	◯	◯	◯
Liquor	◯	◯	◯	◯	◯
Juice	◯	◯	◯	◯	◯
Cow's milk	◯	◯	◯	◯	◯
Plant-based milk (almond, soy, etc)	◯	◯	◯	◯	◯
Sports drinks	◯	◯	◯	◯	◯

Do you filter the water in your home? ◯ Yes ◯ No

How many 8 ounce glasses of water do you drink each day, on average?

- ◯ 9+
- ◯ 6-8
- ◯ 2-5
- ◯ 0-1
- ◯ Other

If "Other", please specify

Check all of the factor that apply:

- ☐ Fast eater
- ☐ Eat too much/overeat
- ☐ Late night eating
- ☐ Crave or eat too much sugar/sweets
- ☐ Do not enjoy cooking
- ☐ Love to cook
- ☐ Negative relationship with food
- ☐ Do not plan meals or menus
- ☐ Family members have different dietary needs/preferences
- ☐ Live or often eat alone
- ☐ Not enough time to cook or eat healthy
- ☐ Rely on convenience items
- ☐ Emotional eating
- ☐ Organic food is important to me
- ☐ Love to eat
- ☐ Travel frequently
- ☐ Confused about nutrition advice
- ☐ Drink too much alcohol

What questions do you have about your nutrition or eating patterns?

Lifestyle

When was the last time you felt well?

With whom do you live?
Include pets, children, roommates, partner/spouse, etc.

Do you engage in moderate physical activity for 20+ minutes on 3+ days per week? ◯ Yes ◯ No

Activity

	Low intensity	Moderate intensity	High intensity	How often?
Stretching/yoga	☐	☐	☐	
Cardio/Aerobics	☐	☐	☐	
Strength Training	☐	☐	☐	
Sports or Recreation	☐	☐	☐	
Walking	☐	☐	☐	

Do you have any issues that limit your physical activity? Please describe.

Do you smoke or chew tobacco? ○ Yes ○ No

Are you exposed to secondhand smoke? ○ Yes ○ No

Do you currently use cannabis? ○ Yes ○ No

Do you currently use psilocybin, cocaine, heroin, speed, LSD, etc? ○ Yes ○ No

Which describe(s) your current employment status?
Check all that apply.

- ☐ Full-time job
- ☐ Seasonal work
- ☐ Retired
- ☐ Part-time student
- ☐ Part-time job
- ☐ Not employed
- ☐ Self-employed
- ☐ Full-time student

Where do you work or study?

Daily Stressors

Rate how stressful you find each of the following on a scale of 1-10. 1= not at all stressful; 10 = extremely stressful.

Stressors	
Work/School	
Family	
Social life	
Finances	
Health	

Have you experienced any particularly stressful events in the past 10 years?

This includes death of a family member, moving, job loss, pregnancy loss, etc.

What do you do to relieve stress and/or relax?

What creative outlets do you have and/or what do you do for fun?

Sleep

How many hours do you sleep per night during the week or on workdays, on average?

- ◯ 10+
- ◯ 8-10
- ◯ 6-8
- ◯ Less than 6

How many hours do you sleep per night on the weekend or on your days off, on average?

- ◯ 10+
- ◯ 8-10
- ◯ 6-8
- ◯ Less than 6

Sleep overview

	Yes	No	Notes/Comments
Do you have trouble falling asleep?	☐	☐	
Do you feel rested when you wake?	☐	☐	
Do you wake up during the night?	☐	☐	
Do you use anything to help you fall or stay asleep?	☐	☐	

How would you rate the overall quality of your sleep?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

1 = Poor, 5 = Excellent

Oral Health

Do you visit a dentist regularly? (Twice per year) ○ Yes ○ No

Do you brush and floss regularly? ○ Yes ○ No

Do you have:

- ☐ Tooth pain
- ☐ Gingivitis
- ☐ TMJ
- ☐ Swallowing problems
- ☐ Bleeding gums
- ☐ Chewing problems
- ☐ Frequent bad breath/halitosis
- ☐ Mercury fillings

Environmental History

Do you experience or have you been diagnosed with chemical sensitivities? ○ Yes ○ No

Are you exposed regularly to any of the following?

- ☐ Aluminum cookware
- ☐ Auto exhaust/fumes
- ☐ Heavy metals
- ☐ Mold

- [ ] Paint fumes
- [ ] Pesticides or herbicides
- [ ] Hair dyes
- [ ] Pet dander
- [ ] Fertilizers
- [ ] Lead paint or pipes
- [ ] Nail polish/remover
- [ ] Perfumed/scented products
- [ ] Paper receipts
- [ ] Dry cleaned laundry

Readiness Assessment

If you had to guess, what two changes could you make now that would make the most difference in the way you feel?

As part of our work together, are you interested in:

Please check all that apply.

- ☐ Dietary recommendations
- ☐ Supplement recommendations
- ☐ Herbal recommendations
- ☐ Coaching and motivational support

How often do you anticipate needing/wanting to schedule appointments?

- ◯ I prefer to meet every 2-3 weeks to keep myself accountable and check in
- ◯ I anticipate needing to meet every month or two
- ◯ I just want a second pair of eyes on my plan; I don't anticipate needing additional support after the first two visits
- ◯ Not sure/whatever is recommended
- ◯ Other

If "Other", please specify

When it comes to herbs and supplements:

Please select all that apply.

- ☐ I prefer not to take herbs/supplements
- ☐ I am on a very tight budget and need to keep costs as low as possible.
- ☐ I am open to using herbal teas
- ☐ If it doesn't taste good, I'm not likely to take an herbal tea or tincture
- ☐ I have an extensive herbal apothecary already
- ☐ I prefer to incorporate herbs into my foods when possible
- ☐ Price is not an issue; I want the best option for me regardless of cost
- ☐ I am open to taking capsules or tablets
- ☐ I am open to using herbal tinctures (alcohol-based extracts)
- ☐ I prefer to make my own herbal products when possible
- ☐ I have a garden and grow/am interested in growing herbs

In order to improve your health, how willing are you to:
Rate on a scale of 1 (not willing) to 5 (very willing)

	5	4	3	2	1
Significantly modify your diet	◯	◯	◯	◯	◯
Keep a food journal	◯	◯	◯	◯	◯
Track other inputs (e.g. mood, exercise, bowels, etc)	◯	◯	◯	◯	◯
Modify your lifestyle (e.g. sleep habits, movement, etc.)	◯	◯	◯	◯	◯
Practice a daily relaxation technique	◯	◯	◯	◯	◯
Take herbs or nutritional supplements as recommended	◯	◯	◯	◯	◯

Is there anything that might get in the way of our work together?

Thank you for taking the time to share a bit about your health history. Sometimes getting it all down on paper (pixel?) helps to clarify the situation and provides a foundation for the healing process. I'm looking forward to going over this information with you when we meet. If you have any questions before then, please send me a message.

Talk soon!

Liz