



**PART I: GENERAL INFORMATION**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_)\_\_\_\_-\_\_\_\_ E-Mail \_\_\_\_\_

Cell Phone Number (\_\_\_\_)\_\_\_\_-\_\_\_\_

Date Of Birth \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Referred By \_\_\_\_\_

**PART II: HEALTH HISTORY**

Please check all that apply:

<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Lyme Disease
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Irritable Bowel Syndrome
<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Crohn's Disease
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Back/Neck Injury	<input type="checkbox"/>	Skin Conditions
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Environmental Allergies
<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Chemical Sensitivities
<input type="checkbox"/>	AIDS/HIV Positive	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Other (List Below)
<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Developmental Delay	<input type="checkbox"/>	
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	

Please list your major health concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please list your major health goals in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list all medication that you are currently taking:

\_\_\_\_\_

Do you smoke? If so, how many packs per day? \_\_\_\_\_

Do you have a high level of stress? \_\_\_\_\_

Do you sleep well at night? How many hours per night do you sleep? \_\_\_\_\_

\_\_\_\_\_

How much water do you consume per day? \_\_\_\_\_

Do you crave certain foods? If so, what are they? \_\_\_\_\_

\_\_\_\_\_

Is there anything else about your health you would like to share with me?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please tell me your typical diet and meals you have at breakfast, lunch and dinner:

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Breakfast	Lunch	Dinner

What types of snacks do you have mid-morning and mid-afternoon? \_\_\_\_\_

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Are you constipated or do you have loose bowel movements? How often do you have bowel movements per day?

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Please list all nutritional supplements you are currently taking: \_\_\_\_\_

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What type of exercise do you do? How many times per week do you exercise?

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Is there anything else about your health you would like to share with me?

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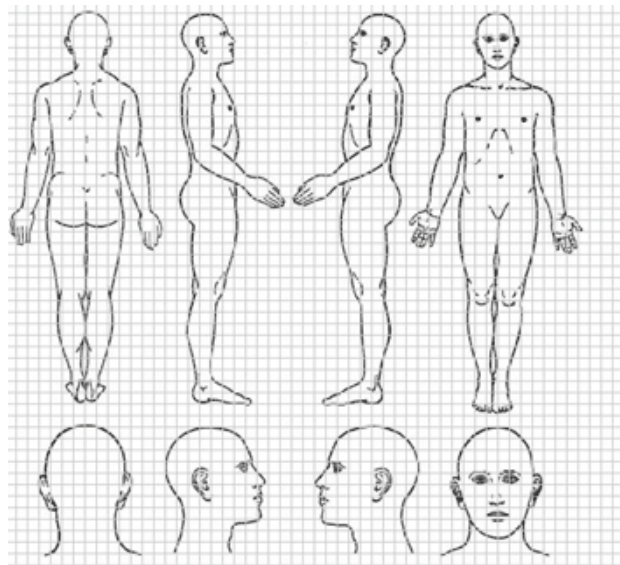
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Do you have any pain in your body? If yes, please describe where the pain is and locate the pain on the diagram below:

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Physician's Name \_\_\_\_\_

Office Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

I request that Joy Feldman perform a nutritional evaluation and set up a diet and supplement program for the purpose of enhancing health and improving well being. I understand that nutritional analysis is a means to reduce stress by identifying and correcting nutritional deficiencies and imbalances. It is not intended as diagnosis, treatment or prescription for any mental or physical disease.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**CIRCLE** any conditions or symptoms that presently describe you.

**PLACE A STAR** next to the symptoms most important to you.

- |                            |                           |                         |
|----------------------------|---------------------------|-------------------------|
| Joint Pain                 | Hyperthyroidism           | Kidney Stones           |
| Joint Stiffness            | Acne                      | Water Retention         |
| Arthritis, Otheo           | Eczema                    |                         |
| Arthritis, Rheumatoid      | Fungal                    | Sinus Headaches         |
| Muscle Pain                | Infections/Candida        | Tension Headaches       |
| Muscle Weakness            | Psoriasis                 | Migraine Headaches      |
| Muscle Cramps              | Hives                     | Neuritis                |
| Bursitis                   | Hair Loss                 |                         |
| Fractures                  | Slow Wound Healing        | Constipation            |
| Osteoporosis               | Cataracts                 | Diarrhea                |
| Gout                       | Glaucoma                  | Intestinal Gas          |
|                            | Meniere's Disease         | Bloating                |
| Sweet Cravings             | Tooth Decay               | Heartburn               |
| Sugar Reactions            | Excessive Plaque on teeth | Ulcer                   |
| Irritable Before Meals     | Gum Disease               | Stomach Pain            |
| Can't Skip Meals           |                           | Colitis                 |
| Hypoglycemia               | Infections/Viruses        | Gall Stones             |
| Crave Starches             | Tumors/Cancer             | Fissures                |
| Fat Cravings               | Multiple Sclerosis        | Hemorrhoids             |
| Other Food Cravings        | Parkinson's Disease       | Cirrhosis               |
| Food Allergies             | Scleroderma               | Diverticulitis          |
| Excessive Hunger           |                           | Tend to Gain Weight     |
| No Hunger                  | Anger                     | Tend to Lose Weight     |
| Diabetes                   | Anxiety                   |                         |
|                            | Bipolar Disorder          | Anemia                  |
| Rapid Heart Rate           | Brain Fog                 | Easy Bruising           |
| Skipped Heart Beats        | Confusion                 |                         |
| Heart Palpitations         | Depression                | Drug Addiction          |
| Heart Attack               | Irritability              | Alcoholism              |
| Poor Circulation           | Mind Races                | Smoking                 |
| Dizziness                  | Mood Swings               |                         |
| Low or High Blood Pressure | Obsessive/Compulsive      | <b>WOMEN:</b>           |
| Angina                     | Panic Attacks             | Premenstrual Syndrome   |
| Arteriosclerosis           | Poor Memory               | Water Retention         |
| High Cholesterol           | Schizophrenia             | Cramps                  |
| High Triglycerides         | Trouble Sleeping          | No Menstruation         |
|                            |                           | Heavy Periods           |
| Cough                      | Autism                    | Light/Irregular Periods |
| Bronchitis                 | Attention Deficit         | Ovarian Cysts           |
| Asthma                     | Hyperkinesis              | Fibroid Tumors          |
| Post-Nasal Drip            | Dyslexia                  | Abnormal Pap Smear      |
| Sinus Congestion           | Seizures                  | Menopause               |
| Allergies                  | Learning Disability       | Fibrocystic Breasts     |
| Emphysema                  | Mental Retardation        | Breast Tumors           |
|                            | Delayed Development       | Yeast Infections        |
| Fatigue                    |                           | Hot Flashes             |
| Hypothyroidism             | Bladder Infections        |                         |
| Low Body Temperature       | Kidney Infections         | <b>MEN:</b>             |
| Cold in Winter/Dry skin    | Trouble Urinating         | Prostate Problems       |
| Tend to gain weight        | Frequent Urination        | Impotence               |
|                            | Painful Urination         | Infertility             |

Other symptoms or comments: