New Client Health History and Intake Form

Today's Date: ___________ How did you hear about Trovato Nutrition? ____________________________________

Personal Information

Last Name: ____ First Name: _______________________________

Preferred Name: __________________________ Date of Birth: _____________________ Age: _________________

Street Address: ____

City: ______________________ State: ____________ Zip: ____________ Email address: ___________________

Home Phone: (___)_______________ Cell Phone: (___)_______________ Work Phone: (___)_______________

Emergency Contact: _______________________________ Contact Number: _______________________________

Occupation

Place of Employment/Occupation ____

Type Work: ☐ Light Activity (Desk Job) ☐ Medium Activity (On feet most of day) ☐ High Activity (Manual Labor)

Exercise

How many days a week do you exercise? ____

What kind of exercise do you perform? ____

Medical History

Please list any health related concerns, issues, symptoms, conditions, that you have.

1. ____ Length of time ___________________
2. ____ Length of time ___________________
3. ____ Length of time ___________________
4. ____ Length of time ___________________
5. ____ Length of time ___________________

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure/Disease	Yes	No	Cancer	Yes	No	Easy Bruising	Yes	No
Heart Attack	Yes	No	Radiation Therapy	Yes	No	Epilepsy or Seizures	Yes	No
High Cholesterol	Yes	No	Chemotherapy	Yes	No	Lyme	Yes	No
Leaky Gut	Yes	No	Emphysema	Yes	No	Anxiety/Panic Attacks	Yes	No
Digestive Issues	Yes	No	Tuberculosis	Yes	No	Anorexia/Bulimia	Yes	No
High Blood Pressure	Yes	No	Chronic Cough	Yes	No	Bleeding Gums	Yes	No
Arteriosclerosis	Yes	No	Sinus Issues	Yes	No	Ringing/Buzzing in Ear	Yes	No
Artificial Heart Valve	Yes	No	Asthma	Yes	No	Loss of Hearing	Yes	No
Heart Pacemaker	Yes	No	Seasonal Allergies	Yes	No	Fainting or Dizzy Spells	Yes	No
Heart Surgery	Yes	No	Respiratory Problems	Yes	No	Whiplash Injury	Yes	No
Stroke	Yes	No	Latex Allergy	Yes	No	Headaches	Yes	No
Rheumatic Fever	Yes	No	Codeine Allergy	Yes	No	Chronic Facial Pain	Yes	No
Anemia	Yes	No	Penicillin Allergy	Yes	No	Pain in Jaw Joint	Yes	No
Arthritis	Yes	No	Sulfa Allergy	Yes	No	Clicking, Popping Jaw	Yes	No
Rheumatism	Yes	No	Hepatitis A (infectious)	Yes	No	Locking Jaw	Yes	No
Artificial Joints (hip, etc.)	Yes	No	Hepatitis B (serum)	Yes	No	Tired Jaw After Sleep	Yes	No
Liver Disease	Yes	No	Hepatitis C	Yes	No	Tired Jaw After Meal	Yes	No
Kidney Trouble	Yes	No	Venereal Disease	Yes	No	Difficulty Opening Wide	Yes	No
Diabetes	Yes	No	Cold Sores/Fever Blisters	Yes	No	Teeth Clenching	Yes	No
Ulcers	Yes	No	Blood Transfusion	Yes	No	Teeth Grinding at Night	Yes	No
Thyroid Problems	Yes	No	Hemophilia	Yes	No	Snoring	Yes	No
Glaucoma	Yes	No	Sickle Cell Disease	Yes	No	Chronic Stuffed Nose	Yes	No

Do you have or have you had any disease, condition or problem not listed above? Yes No

If yes, please identify: ______________________________

List any ***medications*** you are taking. (Attach separate sheet if needed.)

1. ______________________________ Dose: ______________
2. ______________________________ Dose: ______________
3. ______________________________ Dose: ______________
4. ______________________________ Dose: ______________
5. ______________________________ Dose: ______________

List any ***vitamins, herbs, supplements, and/or homeopathic remedies*** you are taking.
Please specify if they were recommended by your practitioner or if you are taking them on your own.
(Attach separate sheet if needed.) Circle One

1. ______________________ Dose: ____________ Practitioner Self
2. ______________________ Dose: ____________ Practitioner Self
3. ______________________ Dose: ____________ Practitioner Self
4. ______________________ Dose: ____________ Practitioner Self
5. ______________________ Dose: ____________ Practitioner Self
6. ______________________ Dose: ____________ Practitioner Self
7. ______________________ Dose: ____________ Practitioner Self

Dental History

Answer Yes or No to the best of your knowledge

Do you currently have amalgam/silver fillings? ☐ Y ☐ N ☐ I don't know

Do you have porcelain-fused-to-metal crowns (caps)? ☐ Y ☐ N ☐ I don't know

Do you have root canalled teeth? ☐ Y ☐ N ☐ I don't know

Do you have missing teeth? ☐ Y ☐ N ☐ Only missing wisdom teeth

Do you wear a removable partial or a full denture? ☐ Y ☐ N

Do you have dental implants? If yes, please circle: **titanium** **ceramic** ☐ Y ☐ N

Do your gums bleed when you brush or floss? ☐ Y ☐ N

When was your last professional cleaning? ____

Weight / "Diet" History and Nutritional Assessment

Height ________________ Current Weight _________________ Desired Weight _________________

Have you ever tried any of the following?

No/low carb diets	☐ Y	☐ N	Liquid diets	☐ Y	☐ N
Low fat diets	☐ Y	☐ N	Diet Pills	☐ Y	☐ N
Vegetarian	☐ Y	☐ N	Ketogenic Diet	☐ Y	☐ N
Vegan diets	☐ Y	☐ N	Fasting	☐ Y	☐ N
Other	☐ Y	☐ N	Please explain __________________________________		

Do you follow a specific diet/way of eating? ☐ Atkins ☐ Paleo ☐ Keto ☐ Vegetarian ☐ Vegan ☐ Other____________

Do you regularly skip meals? ☐ Y ☐ N If yes, which meal(s) and why? ____________________________________

How many times **per day** do you consume vegetables?
☐ Never ☐ Once a day ☐ As much as I can (when available/in season) ☐ At least one vegetable at every meal

How many times **per day** do you consume fruits?
☐ Never ☐ I eat some, but in moderation ☐ I eat more fruits than I do vegetables

How often do you choose **organic** fruits and vegetables?
☐ Never ☐ Sometimes ☐ As much as I can (when available/in season)

How often do you choose **grass-fed/pasture-raised** animal products?
☐ Never ☐ Sometimes ☐ As much as I can (when available)

How many times **per day** do you consume grains / starchy carbohydrates?
☐ Never ☐ I eat some, but in moderation ☐ I eat bread, pasta, rice, cereal, oatmeal, chips, etc.

Do you have any current dietary restrictions or foods you avoid on purpose?

Do you have any foods that you won't eat because you simply do not like them?

What are some foods that you enjoy eating?

Do you create smoothies using either a blender or a juicer? **(if yes, record all ingredients on the intake section)**

Hydration

How much water do you drink per day? ____

What is your drinking water source? (Circle)

Tap Bottled Carbon Filtered Reverse Osmosis Distilled Well Alkaline Ionizer

Please specify how many of the following you drink *per week*: (example: 1 a day would be 7 per week)

_______ Alcohol
_______ Coffee
_______ Green/herbal tea
_______ Soda
_______ Diet soda
_______ Fruit juice
_______ Energy drinks (Red Bull, Monster, etc.)
_______ Sports drinks (Gatorade, Powerade, etc.)

Do you use artificial or alternatives sweeteners like Aspartame, Saccharin, honey, Agave, Stevia instead of sugar?
If so, which ones ____

Do you create green smoothies using either a blender or a juicer? ☐ Y ☐ N (If yes, record all ingredients on the intake section)

Typical 3-Day Dietary Intake

(THIS IS MOST IMPORTANT PART OF INTAKE FORM)

As truthfully as possible, please include examples of foods and drinks that you regularly consume throughout the day. This page can be completed as a journal (filled out as you eat the foods for 3 days), or it can be completed immediately by listing the foods you commonly include for each meal. The purpose of this journal is not to critique your diet, although we will address anything glaringly detrimental to overall health. I am looking for specifics as well as trends to get a baseline idea of the typical foods consumed on a regular basis. Thank you for your time, effort, and honesty.

DAY 1

Breakfast:

____
____
____
____

Lunch:

____
____
____
____

Dinner:

____
____
____
____

Snacks:

____
____
____

Exercise

____
____
____

DAY 2

Breakfast:

Lunch:

Dinner:

Snacks:

Exercise

DAY 3

Breakfast:

Lunch:

Dinner:

Snacks:

Exercise

Consent

I consent to a nutritional consult.

- I understand that the above information is necessary for Trovato Nutrition to provide me with care in a safe manner. I have answered all questions truthfully and to the best of my knowledge.
- I understand that all information provided and recommendations given are to support my body to allow it to heal. Trovato Nutrition does not diagnose nor treat conditions / disease.
- I authorize the release of examination findings, treatment program, etc. to my referring or treating healthcare provider.
- I understand that all responsibility for payment for services provided in this office for myself and/or for my dependents is mine, payable at the time services are rendered unless other arrangements have been made.
- I understand that it is my responsibility to advise this office of any changes in the information contained on this form.
- If I am 21 years of age or older and if my parents/guardians are my guarantors, I give permission for Trovato Nutrition to place a phone call to my parents/guardians regarding account balances and/or account credits and/or to mail statements or other information to my parents/guardians regarding those account balances and/or account credits.
- If I am 21 years of age or older and if my parents/guardians are my guarantors, I give permission for Trovato Nutrition to speak to my parents/guardians on my behalf about my existing conditions, recommended treatment, appointments, fees, or other matters that may be relevant to treatment proposed.
- I understand that Trovato Nutrition provides information and advice but that it is ultimately my responsibility to make an educated decision based on the information, my personal situation, and health. I always have the final decision to follow advice or not. I am responsible for my effort to apply prescribed changes to my life. I understand that results are not guaranteed.
- I understand that the ultimate goal of any nutritional program is to restore the body to homeostasis, allowing it to experience balance and heal itself naturally.
- **Most importantly, I understand that consistency is important to any dietary or health-related application. Whether it regards making and maintaining dietary changes, committing to and executing an exercise program, or taking supportive supplementation, without honest adherence, you cannot achieve results.**

Client Print Name ____

Client Sign Name _______________________ **Date** __________

If under 21:
Parent or Responsible Party ____________________________________

Relationship to Guest ______________________ Date ______________