

Confidential Case History

| | | |
|-----------------------|------------------------------|-----------------------------|
| <i>NAME</i> | | <i>DATE</i> |
| <i>ADDRESS</i> | | |
| <i>CITY</i> | <i>STATE</i> | <i>ZIP CODE</i> |
| <i>DATE OF BIRTH</i> | <i>AGE</i> | <i>M</i> ____ <i>F</i> ____ |
| <i>MARITAL STATUS</i> | <i>NO. OF CHILDREN</i> _____ | |
| <i>OCCUPATION</i> | <i>HOME #</i> | <i>WORK #</i> |
| <i>CELL PHONE</i> | <i>HEIGHT</i> _____ | <i>WEIGHT</i> ____ |
| <i>E-MAIL ADDRESS</i> | | |

Who is responsible for this account? _____

Referred by: _____

Present symptoms: _____

When did symptoms begin? _____

Please explain any major events either emotional or physical that has occurred within 2 years of the time you began to experience your current symptoms:

Have you had any recent immunizations? _____ If so, please list them here: _____

What is your daily stress level on a scale of 1-10?

1 2 3 4 5 6 7 8 9 10

Are your present symptoms becoming progressively worse?:

Yes ____ No ____ Constant ____ Comes & Goes _____

Has there been a medical diagnosis? _____

If yes, What is the diagnosis? _____

By Whom? _____ Address: _____

Do you have current blood work? _____

If so, are you able to bring a copy of it with you on the day of your visit?

Have you ever been hospitalized? _____

If yes, When and why? _____

Do you know your blood type? If so, what is your type?

Are you currently pregnant? _____ When is your due date? _____

Are you currently nursing? _____

Do you have any known allergies? _____

If yes, to what? _____

Are you taking any of the following?

- Laxatives Sedatives
- Aspirin Vitamins
- Ibuprofen Minerals
- Insulin Herbs

Do you have an ulcer? _____ If so, How long? _____

Do you smoke? _____ If so, how much? _____ Per Day/Week/Month

Do you drink alcohol? _____ If so, what do you drink? _____

How Much & How often? _____

Per Day/Week/Month

How often do you drink coffee? _____ Per Day/Week/Month

How often do you drink soft drinks? _____ Per Day/Week/Month

Do you drink diet soda? _____ Per Day/Week/Month

Do you overeat? _____ If so, which foods and how often?

Do you have any food allergies, environmental allergies, restrictions, or sensitivities? If so, please list them here:

Do you get noticeably irritable, lightheaded, or weak if you haven't eaten in a few hours?

Please list any food aversions and/or foods you dislike: _____

How often do you eat at home/cook your own meals? _____
Per Day/Week/Month

Do you crave any of the following frequently?

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Sweets/Desserts | <input type="checkbox"/> Meat | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Fish | <input type="checkbox"/> Alcoholic Drink |
| <input type="checkbox"/> Diet Sodas | <input type="checkbox"/> Milk/Cheese | <input type="checkbox"/> Bread/Pasta |
| <input type="checkbox"/> Salty Foods | <input type="checkbox"/> Fried Foods | <input type="checkbox"/> Sour Foods |
| <input type="checkbox"/> Spicy Foods | <input type="checkbox"/> Bland Foods | <input type="checkbox"/> Candy |
| <input type="checkbox"/> Fats | <input type="checkbox"/> Other _____ | |

Which oils do you currently consume?

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Butter | <input type="checkbox"/> Sesame Oil | <input type="checkbox"/> Soybean Oil |
| <input type="checkbox"/> Margarine | <input type="checkbox"/> Peanut Oil | <input type="checkbox"/> Canola Oil |
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Corn Oil | <input type="checkbox"/> Sun/Safflower Oil |
| <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Crisco | <input type="checkbox"/> Mayonnaise |
| <input type="checkbox"/> Flaxseed Oil | <input type="checkbox"/> Vegetable Oil | <input type="checkbox"/> Other _____ |

Rank the condition of your skin without lotion:

- | | | |
|-----------------------------------|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Very Dry | <input type="checkbox"/> Dry | <input type="checkbox"/> Normal |
| <input type="checkbox"/> Oily | <input type="checkbox"/> Combination | |

Rank the condition of your hair:

- | | | |
|-----------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Very Dry | <input type="checkbox"/> Dry | <input type="checkbox"/> Normal |
| <input type="checkbox"/> Oily | <input type="checkbox"/> Dandruff | |

PLEASE CHECK OFF ANY OF THE FOLLOWING THAT PERTAIN TO YOU (RECENT PAST OR PRESENT):

- | | | |
|---|--|--|
| <input type="checkbox"/> Acne/Blemishes | <input type="checkbox"/> Addiction (Drugs, Alcohol) | <input type="checkbox"/> ADD |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Anxiety or Nervousness | <input type="checkbox"/> Arthritis (Rheumatoid or Osteo) | <input type="checkbox"/> AutoImmune Disease |
| <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Bladder Infections (Cystitis) | <input type="checkbox"/> Bloating, Gas, or Indigestion |
| <input type="checkbox"/> Blood Sugar Problems | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Candida | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Crohns Disease | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Colds or Flu (Frequent) |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Constipation | <input type="checkbox"/> Dandruff |

- | | | |
|--|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes I (Insulin Dependent) | <input type="checkbox"/> Diabetes II (Adult Onset) |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty <i>Losing</i> Weight | <input type="checkbox"/> Difficulty <i>Gaining</i> Weight |
| <input type="checkbox"/> Emotional Problems (Instability or Sensitivity) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Hair Loss or Poor Hair Growth | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Herpes Type I (Mouth/Face) | <input type="checkbox"/> Herpes Type II (Genital) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> IBS | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Infertility | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Loose Stools | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Lupus (SLE or Discoid) |
| <input type="checkbox"/> Memory Loss or Confusion | <input type="checkbox"/> Menopausal Symptoms | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Nails, Poor Growth | <input type="checkbox"/> Nails, White Spots | <input type="checkbox"/> Painful Joints |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Pregnant or Nursing Mother | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Seizures | <input type="checkbox"/> Severe Mood Swings |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Condition (Hypo) |
| <input type="checkbox"/> Sweats (Cold) | <input type="checkbox"/> Sweats (Hot) | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Thyroid Condition (Hyper) | <input type="checkbox"/> Ulcer | |
| <input type="checkbox"/> Other: _____ | | |

Women: Please check any that pertain:

- PMS
 - Irregular Periods
 - Vaginal Discharge
 - Painful Menstrual Cramps
 - Birth Control Pills
 - Menopause- Since When?
-
- Low or Decreased Libido
 - Painful Intercourse
 - Hysterectomy

Men: Please check any that pertain:

- Frequent Urination
- Difficulty Urinating
- Burning Upon Urination
- Low or Decreased Libido
- Prostate Enlargement
- Excess Perspiration
- Athletes Foot
- Jock Itch

- Fertility Concerns
- Menstruation Scanty or Missing
- Painful/Cystic Breasts
- IUD

How many pregnancies? _____ Abortions? _____ Miscarriages? _____

How many bowel movements daily? _____

Do you have a history of constipation? _____

Do you know what your blood pressure is? _____

Do you have your Tonsils? _____ Appendix? _____ Adenoids? _____

What is your cholesterol level? _____

Acne? _____ Nail Problems? _____ Rashes? _____

ANY history of yeast infections? _____ How often? _____

ANY history of antibiotic use? _____

Mouth/Teeth-Cavities? _____ Fillings? _____ Root Canals? _____

Have you had ANY recent or past major dental procedures? _____

If yes, When? _____

Have you been tested for heavy metals recently or in the past? _____

Do you exercise? _____ If so, what form of exercise? _____

How often? _____ Since When? _____

Do you take ANY nutritional supplements or vitamins? If so, which ones? (Be specific. Make sure to include brands. Attach a separate sheet if necessary)

Which **prescription drugs** and over the counter medications do you currently take?

Have you ever done a cleansing fast? _____ If so, when and/or how often?

Have you ever had dietary restrictions to follow before? _____
How did you do with those restrictions? _____

Have you ever had nutritional guidance before? _____
If so, with whom? _____

Please list any disease, illness, or ailments in your immediate family (i.e. Mother- Breast Cancer, Father- Type II Diabetic, Grandfather- Heart Disease etc.)
Do you have siblings? How is their health status? _____

Please rate the following:

DAILY ENERGY LEVEL:

- Excellent
- Good
- Fair
- Poor

ENERGY LEVEL AFTER EXERCISE:

- Excellent
- Good
- Fair
- Poor

DAILY STRESS LEVEL:

- Very Hight
- High
- Moderate
- Low
- None

GENERAL ENJOYMENT OF LIFE:

- Excellent
- Good
- Fair
- Poor

What time of day do you have the most energy? _____
What time of day do you have the least energy? _____
How much sleep do you get on average each night? _____
Any problems sleeping? _____

Please feel free to expand on any concerns you think are important/relevant to your health

What are your long terms goals in regard to your health? _____

What are you looking to achieve from our meeting? _____

How important is it for you to be well? _____

And how hard are you willing to work to get there? (Circle One)

VERY LITTLE

SOMEWHAT

WHATEVER IT TAKES

How stringent do you feel you can be with your diet if you had to?

VERY LITTLE

SOMEWHAT

WHATEVER IT TAKES

**Please check off the Vegetables, Fruits, & Proteins you like or
would be willing to eat**

(if you don't know what it is, do NOT check it)

Vegetable List

- | | |
|--|---|
| <input type="checkbox"/> Alfalfa Sprouts | <input type="checkbox"/> Leeks |
| <input type="checkbox"/> Artichoke | <input type="checkbox"/> Lentils |
| <input type="checkbox"/> Arugula | <input type="checkbox"/> Lettuce (romaine, baby greens, etc.) |
| <input type="checkbox"/> Asparagus | <input type="checkbox"/> Mushrooms |
| <input type="checkbox"/> Beans (black, lima, etc.) | <input type="checkbox"/> Mustard greens |
| <input type="checkbox"/> Beets | <input type="checkbox"/> Okra |
| <input type="checkbox"/> Black eyed peas | <input type="checkbox"/> Onions |
| <input type="checkbox"/> Broccoli | <input type="checkbox"/> Parsley |
| <input type="checkbox"/> Brussels sprouts | <input type="checkbox"/> Parsnips |
| <input type="checkbox"/> Cabbage | <input type="checkbox"/> Peas |
| <input type="checkbox"/> Carrots | <input type="checkbox"/> Peppers (red or green) |
| <input type="checkbox"/> Cauliflower | <input type="checkbox"/> Potato |
| <input type="checkbox"/> Celery | <input type="checkbox"/> Pumpkin |
| <input type="checkbox"/> Chard | <input type="checkbox"/> Radicchio |
| <input type="checkbox"/> Chives | <input type="checkbox"/> Radishes |
| <input type="checkbox"/> Collard greens | <input type="checkbox"/> Rhubarb |
| <input type="checkbox"/> Corn | <input type="checkbox"/> Rutabaga |
| <input type="checkbox"/> Cucumber | <input type="checkbox"/> Spinach |
| <input type="checkbox"/> Eggplant | <input type="checkbox"/> Squash |
| <input type="checkbox"/> Endive | <input type="checkbox"/> Sweet Potato |
| <input type="checkbox"/> Fennel | <input type="checkbox"/> Tomato |
| <input type="checkbox"/> Garlic | <input type="checkbox"/> Turnips |
| <input type="checkbox"/> Ginger | <input type="checkbox"/> Water chestnuts |
| <input type="checkbox"/> Green beans | <input type="checkbox"/> Yams |
| <input type="checkbox"/> Kale | <input type="checkbox"/> Zucchini |
| <input type="checkbox"/> Kelp | |

Fruit List

- | | | |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Apple | <input type="checkbox"/> Grapefruit | <input type="checkbox"/> Peach |
| <input type="checkbox"/> Apricots | <input type="checkbox"/> Grapes | <input type="checkbox"/> Pear |
| <input type="checkbox"/> Avocado | <input type="checkbox"/> Guava | <input type="checkbox"/> Persimmon |
| <input type="checkbox"/> Banana | <input type="checkbox"/> Honeydew | <input type="checkbox"/> Pineapple |
| <input type="checkbox"/> Blackberries | <input type="checkbox"/> Kiwi | <input type="checkbox"/> Plum |
| <input type="checkbox"/> Blueberries | <input type="checkbox"/> Lemon | <input type="checkbox"/> Pomegranate |
| <input type="checkbox"/> Boysenberries | <input type="checkbox"/> Lime | <input type="checkbox"/> Prunes |
| <input type="checkbox"/> Cantaloupe | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Raisins |
| <input type="checkbox"/> Cherries | <input type="checkbox"/> Mango | <input type="checkbox"/> Raspberries |
| <input type="checkbox"/> Crabapples | <input type="checkbox"/> Nectarine | <input type="checkbox"/> Strawberries |
| <input type="checkbox"/> Cranberries | <input type="checkbox"/> Orange | <input type="checkbox"/> Tangerine |
| <input type="checkbox"/> Dates | <input type="checkbox"/> Papaya | <input type="checkbox"/> Watermelon |
| <input type="checkbox"/> Figs | <input type="checkbox"/> Passionfruit | |

Proteins

Meats:

- Beef
- Chicken
- Ham
- Pork

Fish & Seafood:

- Cod
- Crab
- Grouper
- Herring
- Lobster
- Mackerel
- Mussels
- Oysters
- Salmon
- Sea Bass
- Shrimp
- Snapper
- Tuna

Dairy:

- Cheese
- Cottage Cheese
- Eggs
- Whey Protein Powder
- Yogurt

Nuts:

- Almonds
- Almond Butter
- Brazil Nuts
- Cashews
- Cashew Butter
- Hazelnuts
- Macadamia Nuts
- Natural Peanut Butter
- Pecans
- Pistachio
- Sesame Butter
- Walnuts

For Children Only:

Please list your favorite foods below:

Please list the foods you dislike below:

By signing below, you acknowledge that any dietary or supplemental suggestions made by Tricia Cardone, CN, are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider, and is responsible for supervising all changes in diet, exercise and nutrient intake that you make.

Signed: _____ Date: _____

Note: Please be sure to fill out this health questionnaire in its entirety. We cannot counsel you if this is not completed by the time of your first visit.

Note: If this is for a scheduled phone consultation, please make sure the history forms are faxed to our office 24 hours prior to your scheduled consult. Fax: 570-421-0664.

Thank you ☺