Nutritional Intake Form

Where do you do most of your grocery shopping?

How many meals per week do you eat in restaurants or cafeterias?

How many meals per day do you eat?

How many snacks per day do you eat?

What percentage of the vegetables that you eat is organic? ☐100% ☐99-90% ☐89-75 ☐74-50 ☐ less than 50 NA

Do you avoid eating grains? Yes☐ No☐Which ones?

Do you drink raw milk? Yes No

Do you consume Cow dairy? Yes No

Do you consume other dairy? Yes☐ No ☐

Do you eat Peanuts or products with peanut oil or peanut butter? Yes☐ No ☐

Do you eat corn, or products with corn oil or other corn derivatives? Yes☐ No ☐

Do you eat soy or products with soy oil or other soy derivatives? ? Yes☐ No ☐

Do you eat wheat? ? Yes☐No ☐

Do you eat eggs? ? Yes☐ No ☐

Do you eat beans? Yes☐ No ☐

Do you think you eat enough vegetables? Yes☐ No ☐ How many cups of vegetables do you average per day?

Do you have a sweet tooth? Yes☐ No☐

How many servings of fruit do you average per day?

Have you ever eliminated any foods?

Food eliminated	Amount of time without any of the food	What did you notice?

Rice can contain arsenic and barrel aged vinegars may contain led, do you know if these are a problem for you? Yes☐ No☐

Do you avoid them? Yes☐ No☐

Where does the water you drink come from? ☐ Well ☐ City /tap water ☐Filtered Other:

Do you eat meat or fish? If no, skip the next three questions. Yes☐ No☐

What percentage of the red meat that you eat is 100% grass fed? ☐100% ☐99-90% ☐89-75 ☐74-50 ☐ less than 50 NA

What percentage of the Chicken or pork that you eat is organic? ☐100% ☐99-90% ☐89-75 ☐74-50 ☐ less than 50 NA

What kinds of fish do you eat?

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What types of nutritional programs or diets have you tried?

	Length of time/dates	What did you notice?
Paleo		
Mediteranean		
Ornish		
Hyman		
Atkins/ketogenic		
SCD		
GAPS		
Other		

Have you ever had any food sensitivity or allergy testing? If so please bring your results with you to your appointment.

Name of Lab	**Date of Lab Test**	**Summary of Results (or bring a copy)**
Cyrex		
Genova		
Doctors Data		
Other Blood test		
Other Test		

Rank you concerns from 1-5 with 1 being your strongest concern. If you are not concerned about something, mark NA

	1	2	3	4	5	NA	Comments
Weight loss	☐	☐	☐	☐	☐	☐	
Gaining weight	☐	☐	☐	☐	☐	☐	
Increasing energy	☐	☐	☐	☐	☐	☐	
Stabilizing energy	☐	☐	☐	☐	☐	☐	
Decreased pain	☐	☐	☐	☐	☐	☐	

Tobacco and Alcohol:

Do you currently smoke cigarettes or chew tobacco? Yes ☐ No ☐
Have you ever smoked cigarettes or chewed tobacco? Yes ☐ No ☐ Amount Per day
Number of years Date quit
Do you currently drink alcoholic drinks? Yes ☐ No ☐
Did you quit drinking alcohol? Yes ☐ No ☐ Date quit
Reason for quitting_____

Caffeine intake:

Type	Amount per day
Green tea	
Black tea	
Coffee	
Sodas	
Other drinks with caffeine	