Byford Healing Arts

Chiropractic – Therapeutic Massage – Nutrition – Exercise – Orthopaedic Supplies

Nutritional Assessment History

Name: _____ **Date: _____**

Age: _____ **Weight: _____** **BP: _____**

Pertinent Medical History: Please CIRCLE the appropriate choices.

1. Were you born naturally, Caesarian, forceps delivery, other: _____
2. Did your mother have a history of antibiotic use? Y / N
   if Yes, for: _____
3. Did your grandmother have a history of antibiotic use? Y / N
4. Did your mother or grandmother have 'digestive issues': Y / N
   if yes, what: _____
5. Please itemise your history of antibiotic use through your entire life:

6. Have you noted consequences of antibiotic use? Y/N – if Yes, what kind of:

7. While a child what did you eat for:

Breakfast:
Lunch:
Dinner:
Snacks:
Drinks:

8. What do you typically eat these days for:

Breakfast:
Lunch:
Dinner:
Snacks:
Drinks:

9. What foods do you dislike?

   _____

10. What foods do you really like?

    _____

11. What foods do you have a known reaction to?

    _____

12. What foods do you crave?

    _____

13. What foods do you think are bad for you?

    _____

14. What foods do you think are good for you?

    _____

15. What did you eat yesterday?

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Medical History Assessment

1. What is your genetic background (e.g. northern European, Native American)
   _____
2. Do you have any chronic illness or physical complaints?

3. What medications are you currently taking?

4. What nutritional supplements/herbal medicines are you taking?

5. What is your history of hospitalisations and surgeries?

6. What is your history of dieting?

7. What is your history of consumption of alcohol and/or recreational drugs?

8. What is your daily physical activity level? - Please include work and recreational activities.

9. Do you have any known dental or chewing problems? Y/N
   If yes, what? _____

10. What recent diagnostic tests have you had?

11. What is your history of smoking?

_____

12. Is there a history of mental illness in your family? Y/N - If Yes, what?

13. Do you have a history of serious physical or mental trauma? Y/N - What and when?

14. Do you think you have suffered any long term problems because of this "trauma"?

15. What illnesses/diseases do your close relatives have: (e.g. mother – heart disease)

16. What do you think your major complaint is?

17. What previous treatments have you tried for your complaints? - What, where and when?

18. Do you have other complaints that you are concerned about?

19. When was the last time you felt really well?