

CLIENT HEALTH HISTORY

ALL APPLICABLE INFORMATION MUST BE FILLED OUT TO SEE THE PRACTITIONER

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell \_\_\_\_\_

SSN \_\_\_\_\_ (required for confidential client file)

Your Profession \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_

Address of Employment \_\_\_\_\_

Age and DOB \_\_\_\_\_ Emergency Name and Number \_\_\_\_\_

Marital / Significant relationship status \_\_\_\_\_

What has brought you here today? \_\_\_\_\_

How did you hear about Integrative Nutritional Therapies? \_\_\_\_\_

Health & Nutrition goals: Short Term \_\_\_\_\_

Health & Nutrition goals: Long Term \_\_\_\_\_

List the 5 top Physical/Emotional complaints/symptoms you currently have in order of importance.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

List all medical conditions for which you are now being treated:

1. \_\_\_\_\_ Duration \_\_\_\_\_
2. \_\_\_\_\_ Duration \_\_\_\_\_
3. \_\_\_\_\_ Duration \_\_\_\_\_
4. \_\_\_\_\_ Duration \_\_\_\_\_

Any known reactions to medications? \_\_\_\_\_

Any known reaction to Iodine or flowers/herbs in the daisy family? \_\_\_\_\_

Please list **medications** you are currently taking: Use additional sheet if necessary.

1. \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Purpose \_\_\_\_\_
2. \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Purpose \_\_\_\_\_
3. \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Purpose \_\_\_\_\_
4. \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Purpose \_\_\_\_\_

Please list **supplements** you are currently taking: **please circle food based or synthetic supplement.** Use additional sheet if necessary.

1. \_\_\_\_\_ food based or synthetic Duration \_\_\_\_\_ Purpose \_\_\_\_\_
2. \_\_\_\_\_ food based or synthetic Duration \_\_\_\_\_ Purpose \_\_\_\_\_
3. \_\_\_\_\_ food based or synthetic Duration \_\_\_\_\_ Purpose \_\_\_\_\_
4. \_\_\_\_\_ food based or synthetic Duration \_\_\_\_\_ Purpose \_\_\_\_\_

Any known allergies (include food/seasonal) or sensitivities?

\_\_\_\_\_

Surgeries or Organ Removals: List the surgery, the purpose **and** the date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Gallbladder removed ?    yes    no

Have you ever taken antibiotics? \_\_\_\_\_ How many (estimated) \_\_\_\_\_

(Female) Are you menstruating (overall)? \_\_\_\_\_ If no, how long ago did you stop? \_\_\_\_\_  
Are you in menopause? \_\_\_\_\_

(Female) Are you currently or have you used synthetic estrogen or progesterone (birth control) (circle)? How long was the use?  
How long ago? Answer all questions.

\_\_\_\_\_

Number of pregnancies? \_\_\_\_\_

Number of live births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Premature births: \_\_\_\_\_ Adopted out: \_\_\_\_\_

Cesarean births: \_\_\_\_\_ Stillbirths: \_\_\_\_\_ Abortions: \_\_\_\_\_ Ectopic pregnancies \_\_\_\_\_

If you have had a miscarriage, how many weeks pregnant were you? \_\_\_\_\_

Have you had an abnormal Pap Test? Yes No Diagnosis/Reason: \_\_\_\_\_

Treatment and/or Medication: \_\_\_\_\_

Have you had a vaginal infection? Yes No Treatment and/or Medication: \_\_\_\_\_

Any history of: Ovarian cysts Yes No Treatment and/or Medication: \_\_\_\_\_

Uterine fibroids Yes No Treatment and/or Medication: \_\_\_\_\_

Fibrocystic Breasts Yes No Treatment and/or Medication: \_\_\_\_\_

Endometriosis Yes No Treatment and/or Medication: \_\_\_\_\_

Polycystic Ovarian Syndrome (PCOS) Yes No Treatment and/or Medication: \_\_\_\_\_

Have you had a hysterectomy \_\_\_\_\_ Uterus/Ovaries/Fallopian tubes Removed? **Circle which ones apply**

Please describe problems that you may have experienced associated with the use of any and all birth control methods (such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.)

Have you used or are you currently using fertility or treatment (circle which apply)? Yes No

If yes, please explain. \_\_\_\_\_

Have you used, or are you currently using, bioidentical hormones or HRT (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.) (circle)? Yes No If yes, what hormone(s), dosage, & for how long?

Form of birth control \_\_\_\_\_

Describe your energy levels: Upon rising \_\_\_\_\_ Mid day \_\_\_\_\_

Early evening \_\_\_\_\_ Late evening \_\_\_\_\_

Daily exercise/movement: What \_\_\_\_\_ How Often \_\_\_\_\_ Cardio \_\_\_\_\_ Strength \_\_\_\_\_

Bowel Movements: per day \_\_\_\_\_ per week \_\_\_\_\_ Loose / Mix / Firm

Constipation \_\_\_\_\_ Diarrhea \_\_\_\_\_ IBS: Yes No Crohns: Yes No Length of symptoms? \_\_\_\_\_

Indigestion / gas / bloating / heartburn. (circle) How often \_\_\_\_\_ Triggers \_\_\_\_\_

Any silver fillings **previous** in teeth? yes no Removed when \_\_\_\_\_ Bridges or root canals (circle), how many \_\_\_\_\_ Mercury fillings **presently** in teeth? yes no How many \_\_\_\_\_

List tattoos and piercing \_\_\_\_\_

Cups of coffee per day Reg \_\_\_\_\_ Decaf \_\_\_\_\_

Cigarettes per day \_\_\_\_\_ packs per week \_\_\_\_\_ second hand smoke exposure per week \_\_\_\_\_

Recreational drugs \_\_\_\_\_

Alcohol drinks per day \_\_\_\_\_ per week \_\_\_\_\_ Type of drink(s) \_\_\_\_\_

Glasses of pop per day \_\_\_\_\_ Diet \_\_\_\_\_ Regular \_\_\_\_\_ Do you drink out of cans? Yes No. How many per week \_\_\_\_\_

Do you use a cell phone? Yes No. Hours per week \_\_\_\_\_ Phone earpiece: Yes No. Hours of use \_\_\_\_\_

How often do you eat microwaved food? Meals per week \_\_\_\_\_

INT Client Health History Form: Revised 1/1/10

Do you use a showerhead *filter*? Yes No

How often do you use artificial sweeteners? (diet pop, sugar-free foods) \_\_\_\_\_

Do you eat fat-free / low-carb or sugar-free foods, weight watchers, healthy choice, nutra system, slim fast, etc..? \_\_\_\_\_  
How often per week \_\_\_\_\_

Water: Purified / Tap / Mix      How many glasses per day \_\_\_\_\_

**Please indicate what immunizations you have had: (circle)**

- DPT (diphtheria, pertussis, tetanus)
- MMR (measles, mumps, rubella)
- Smallpox
- Hepatitis A
- Flu
- Polio
- Hepatitis B
- Gardasil
- Other: \_\_\_\_\_

**Womb History**

**Birth mother's** illnesses during pregnancy (circle):

Hypertension/ Gestational Diabetes/ Pre-eclampsia  
Bleeding /Excessive vomiting /Anemia  
Trauma Other: \_\_\_\_\_

Breast Fed: Y N How long: \_\_\_\_\_

Bottle Fed: Y N How long: \_\_\_\_\_

Introduction of Solid Foods: When? \_\_\_\_\_

First foods in order of introduction (specify if jar or fresh)

\_\_\_\_\_

\_\_\_\_\_

Any reactions to the foods listed above? (colic, diarrhea, constipation, congestion, etc)

\_\_\_\_\_

**Your Current Typical Diet (please be specific)**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

Cravings: \_\_\_\_\_

Aversions: \_\_\_\_\_

Do you have any dietary restrictions? \_\_\_\_\_

Rebuilding may be necessary, are you *opposed* to taking whole food based supplements with organic glandulars? yes no

How often do you eat fast food per week \_\_\_\_\_ Restaurant food per week \_\_\_\_\_

Are you, or were you exposed to new materials; new car, new home, new carpet, new tile, etc..?

\_\_\_\_\_

Describe your emotional/mental state of mind. For example do you feel happy, peaceful, anxious, nervous, bitter, angry, OCD, depressed, calm, emotional, free of guilt, consumed with guilt.

\_\_\_\_\_

In your overall past, how would you describe your eating habits (unhealthy) 0-10 (healthy) \_\_\_\_\_

On a scale of (low) 0-10 (high), what is your commitment level regarding truly getting well? \_\_\_\_\_

What does your total cholesterol levels run? High Low Average      What does your blood pressure run? High Low Average

Are you a vegan or vegetarian? **Specifically** what foods do you not eat? \_\_\_\_\_

If yes to vegan or vegetarian, please **specify** why? \_\_\_\_\_

\_\_\_\_\_

Loss of taste for meat? Yes No; **Please circle one**

During pregnancy, did your **birth mother**:

Have silver fillings yes no not sure

Have yeast infections yes no not sure

Have bacteria infections yes no not sure

Have viral infections yes no not sure

Eat processed food yes no not sure

Type of labor: (circle) Spontaneous/ Induced

Type of delivery: (circle) Vaginal /C-section

Complications after delivery (circle):

Jaundice/ Rash/ Colic/ Seizures

Respiratory Distress /Birth Defects/ Bleeding/

Fever

Other: \_\_\_\_\_

Substances used during pregnancy by birth mother (circle):

Tobacco

Alcohol

Caffeine

Medications

**IT IS THE CLIENTS RESPONSIBILITY TO MAKE A COPY OF THIS PAGE FOR THEIR RECORDS; TO FOLLOW AND UNDERSTAND THESE DISCLAIMERS WHILE WORKING WITH MELISSA MALINOWSKI, ND, CNC**

I acknowledge that all information that is provided for me through this office is **not intended to diagnose, treat or cure any illness or disease and is for my education only and I understand this when discussing any of this information to my medical doctors**. I understand that I will not hold Melissa Malinowski, ND, CNC legally responsible for any services provided or supplements recommended. All information, wellness plan or supplements discussed is to educate me and any decision that I make is my full responsibility. \_\_\_\_\_ initial

I acknowledge that I have filled out all applicable pieces of information on this form and that the above information is my total health picture and that it is true to the best of my knowledge. If any information regarding my health changes, I will inform Melissa Malinowski as soon as possible. \_\_\_\_\_ initial

I understand and agree that nutrition care at this office is **not** covered by insurance and that I am financially responsible for services and supplements rendered at the time of **each consultation**. \_\_\_\_\_ initial

The information exchanged during the consultations is confidential and any information needed to be provided to another health care practitioner or another party needs to have the client and practitioners written consent. \_\_\_\_\_ initial

All decision made regarding clients medications is the sole decision and responsibility of the client and the prescribing doctor and not the decision or suggestion of Melissa Malinowski. \_\_\_\_\_ initial

If there are any changes in my prescribed medication, it is my responsibility to inform Melissa Malinowski, ND, CNC. \_\_\_\_\_ initial

**Consultation Charges:** Initial consultations: \$125 per person. Follow ups: \$50 for first hour and \$1 per minute after that per person. \_\_\_\_\_ initial

**Short notice and no call-no show appointments will be charged a \$50 short notice/missed appointment fee.** \_\_\_\_\_ initial

Confirmation phone calls and/or confirmation e-mails are **required** to reserve each appt. Please return confirmation call or e-mail whether you are or are not able to make your scheduled appt. \_\_\_\_\_ initial

Supplements are non-refundable unless arrangements are made with the practitioner. \_\_\_\_\_ initial

Only plan to bring children to your appointments if they are being tested. \_\_\_\_\_ initial

Because the office does not have a waiting room, showing up early or late for any appointment is discouraged out of respect for the practitioner and other appointments. \_\_\_\_\_ initial

Full commitment to your designed nutritional program is crucial for optimal results. Follow-up appointments are a very significant part of your success. Diet modification and nutritional support may be a fundamental part of your wellness program, therefore it is very important to attend **all** follow-up appointments at their scheduled time. **If you are not able to make your follow-up appointment, please call to reschedule or cancel asap to avoid charge.** \_\_\_\_\_ initial

I have thoroughly filled out, read and acknowledge all the information of this form. I specifically consent to the disclaimers and have initialed each disclaimer on this page.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Parent (if client is a minor) \_\_\_\_\_