

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, Notice of Privacy Practices Apply)

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. Duration-please list how long taken.

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 use the microwave for heating food or water? Per week _____

INT Client Health History Form: Revised 11/1/10

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) - Hepatitis A - Hepatitis B
-MMR (measles, mumps, rubella) -Flu -Gardasil
-Smallpox -Polio -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? _____

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

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 currently working with another practitioner (Chiro, Naturopath, Nutritionist, etc..) with supplements and/or diet? yes no

Are you currently working with a Chiropractor? yes no, if yes: Name of DC _____

Have you ever used Standard Process supplements or MediHerb herbs? yes no

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**

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

We are required by law to maintain the privacy of the protected health information in your records and to provide you with this notice of our legal duties and privacy practices with respect to that information. This privacy notice is located on the practices website (www.integrativenutritiontherapies.com) for your review. I acknowledge that I have read this privacy notice. _____ initial

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 information, services provided or supplements recommended. All information, results of Biomeridian assessment, wellness plan or supplements discussed or recommended is to educate me and any decision that I make is my full responsibility. _____ 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

Consultation Charges: Initial consultations: \$125 per person. Follow ups: \$50 for a maximum of 60 minutes. _____ initial

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

Supplements are non-refundable unless arrangements are made with the practitioner. _____ 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

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

Continuous re-scheduling of scheduled appointment day and time is strongly discouraged. _____ initial

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

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

Based on the strength of this partnership, the practitioner reserves the right to discontinue care at any time if it is determine that dedication is not continuous or for any other professional basis. _____ 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 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

This completed form along with the other completed health profile forms must arrive to this office at least 24 hours prior to the scheduled initial appointment. This gives the practitioner time to thoroughly review your health history. _____ 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) _____