Food Solutions
by Michelle Marshall

GENERAL INFORMATION

Please fill in the form below and bring it to the first appointment.

Name _____
First Middle Last

Date _____

Primary Address _____
Number, Street Apt. No.

_____
City Province Postal code

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Date of Birth _____

Age _____

Gender: Male ☐ Female ☐

Height _____

Weight _____

Job Title _____

Nature of Business _____

Brief Description of your work _____

_____

_____

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HEALTH RECORD – CONFIDENTIAL INFORMATION

Allergies

Medication / Supplement	Food Reaction

Main Health Complaint / Symptoms:

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COMPLAINTS/CONCERNS

When did your illness first begin?

Did something trigger your change in health?

When was the last time you felt well?

What makes you feel worse? (Food, exercise, habits)

What makes you feel better? (Food, exercise, habits)

ORAL THERAPIES

Rx Medications/OTC Meds/ Recreational Drugs:	OTC drugs, vitamins, herbal or homeopathic medicines you are taking and the dosages:

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NUTRITION HISTORY

Have you ever had a nutrition consultation? Yes ☐ No ☐
Have you made any changes in your eating habits because of your health? Yes ☐ No ☐

Describe: _____

Do you currently follow a special diet or nutritional program?
Low Fat ☐ Low Carb ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐
No Wheat ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Other: _____

Do you avoid any particular foods? Why?

_____

_____

If you could eat a few foods a week, what would they be?

_____

_____

Do you grocery shop? Yes ☐ No ☐ If no, who does the shopping? _____
Do you read food labels? Yes ☐ No ☐
Do you cook? Yes ☐ No ☐ If no, who does the cooking? _____

How many meals do you eat out per week? _____

What the most important thing you think you should change about your diet to improve health?

_____

_____

SMOKING

Currently smoking? Yes ☐ No ☐ How many years? _____ Packs per day: _____
Attempts to quit: _____

Previous smoking: How many years? _____ Packs per day: _____

Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? _____ Type: _____

Previous alcohol intake? None ☐ Mild ☐ Moderate ☐ High ☐

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OTHER BEVEREGES

Coffee ☐ Tea ☐ Water ☐ Tap / Brita / other: ☐ Milk ☐ Wine ☐ Fruit Juice ☐
Vegetable Juice ☐ Juicer ☐ Herbal Tea ☐ Soft drinks ☐
Other: _____Chew Gum: ☐

EXERCISE

What do you do for exercise? _____
Frequency: _____
Rate your level of motivation for including exercise in your life? Low ☐ Medium ☐ High ☐

List problems that limit activity: _____
_____

Do you feel unusually fatigued after exercise? Yes ☐ No ☐

Describe: _____

Do you usually sweat when exercising? Yes ☐ No ☐

STRESS/COPING

Do any events/moments in your life stand out as being more stressful?
_____

What do you worry about most in your life?
_____

What do you do to relieve stress and relax?
_____

Do you feel your life has meaning and purpose? Yes ☐ No ☐
Do you believe stress is currently reducing the quality of life? Yes ☐ No ☐
Do you like the work you do? Yes ☐ No ☐

Daily Stressors: Rate on a scale of 1-10
Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? Yes ☐ No ☐ How often: _____

Check all that apply: Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐
Other: _____

Have you ever been abused, a victim of crime, or experienced a significant trauma? Yes ☐ No ☐

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SLEEP

Average number of hours you sleep per night: _____
Do you feel rested upon awakening? Yes ☐ No ☐
Do you use sleeping aids? Yes ☐ No ☐
Describe your sleep routine:

_____
_____
_____
_____

ROLES / RELATIONSHIPS

Single ☐ Married ☐ Divorced ☐ Long/Short Term Partnership ☐ Widow ☐

Child's Name	Age	Gender

Who are the people living in your household?

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I the undersigned, do hereby acknowledge that I have read and agree to the following terms and conditions:

You alone are responsible for your actions and results in life, including your health. As a Culinary Nutrition Expert, I do not claim that anything shared in my programs or classes is intended to diagnose, treat or cure any disease. I make no representations, warranties or guarantees that you will achieve any results from the ideas or recommendations outlined in this program.

Name (Print): _____

Signature: _____ Date:_____

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