Ara Wiseman Nutrition & Healing

NUTRITION PROFILE FORM

Name _____

Address _____

_____

Tel: (H) _____

Tel: (W) _____

Tel: (cell) _____

Email: _____

How did you learn about our services?

_____

_____

If applicable, who referred you to our services?

_____

Nutrition and Health Goals

- ☐ Lose body Fat
- ☐ Weight Management
- ☐ Improved health / prevent disease
- ☐ Improved energy
- ☐ Stress management
- ☐ Rehabilitation of injury / supplements
- ☐ Disease/symptom management
- ☐ other _____

Lifestyle

Occupation_____

Business Travel? _____ Frequency _____

Person responsible for cooking _____ Food shopping _____

How many times/week do you eat out per week?

Breakfast _____ lunch _____ dinner_____ fast food _____

Alcoholic drinks per week _____

Do you currently smoke _____ Have you tried to quit? _____ Do you plan to quit? _____

List any previous diets

_____

What movement do you include in your daily routine? _____

Type of movement/physical activity _____

Rate your current stress level on a scale of 1 through 10 (10 being considerable stress) ____

Have you experienced any significant stressful event during the past 6 months? If so, please provide details _____

How do you cope with stress? _____

How do you relax? _____

Are you interested in learning relaxation techniques? _____

Do you experience restful sleep? _____

How many consecutive hours of sleep do you average each night? _____

Health History

Please list any medical conditions, health concerns or have you had any past illnesses?

_____

Please list any prescribed medication? _____

Please list any vitamins, minerals or natural/homeopathic remedies which you are currently taking and the frequency.

_____

Please list any food allergies?

_____

Do you experience any of the following:

Bodily signs and symptoms:

- ☐ Restless sleep/Insomnia
- ☐ Dry/lifeless hair
- ☐ Cold Hands/feet
- ☐ High/low blood pressure
- ☐ Frequent infections/colds
- ☐ Anxiety/Depression
- ☐ Dry/leathery skin
- ☐ Frequent headaches/ migraines
- ☐ Brittle/slow growing nails

Digestive system concerns after eating a meal:

- ☐ Bloating
- ☐ Heartburn
- ☐ Burping/belching
- ☐ Sleepy/tired

Gastrointestinal System concerns after eating a meal:

- ☐ Irregular Bowel Movements
- ☐ Nausea
- ☐ Frequent Constipation / diarrhea
- ☐ Acid Reflux

Family History

Do any of the following occur in your family?

☐ Heart Disease ☐ Diabetes ☐ High Cholesterol ☐ Osteoporosis ☐ Cancer ☐ High Blood Pressure

Emotional Assessment

Do you consider yourself a positive person? Why or why not?

How does stress affect you and your life?

Do you feel you have healthy relationships and boundaries?

Do you feel you are holding onto any past experiences or resentments?

Do you feel you have too many responsibilities?

Do you feel anything is preventing you from healing or attaining your goals?

Food Journal

Keep track of all foods eaten for two weekdays and one weekend day. Please try to be as specific as possible.

Date **Food Record**

Breakfast

Snack

Lunch

Snack

Dinner

Snack

Food Journal (cont'd)

Keep track of all foods eaten for two weekdays and one weekend day. Please try to be as specific as possible.

Date **Food Record**

Breakfast

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