Empowering the body to heal itself.

Welcome!

On behalf of NWHH, we are excited that you decided to join us today. We want you to know that we believe that each person that walks through our door is supposed to be here. Know that we value your decision and we welcome you.

Please, take a moment. What does real health look like to you? In conventional medical thought, health is seen simply as the absence of symptoms. At NutritionWorks Holistic Health, real health is much more than that. A truly healthy person is a person who is free on all levels – physical, emotional, and mental.

Our mission is to refine health care by educating and empowering you to take control of your own health. The power to heal lies within. True health is an inside job. True health is a lifestyle.

We are here to offer love by providing truth, so that you are free to live a full life. Love is the greatest healer. Truth is the greatest facilitator. Freedom is the greatest benefit.

With Love and In Health,

Your NutritionWorks Holistic Health Team

New Client Information Form

Please print legibly. If does not apply, write X or NA on line. Do not leave anything blank.

General Information:

Name: ____ Date: ____________

Address: ____ Apt. #____________

City: ______________________________ State:__________ ZIP: _____________

Home Phone (____) ____-__________ Cell Phone (____) ____-__________

E-mail address: __________________________ Referred By: _____________________

Occupation: _______________________ Employer: ___________________________

Date of Birth: ________________ Age: ____ Height: _____ Weight: ____

Health History:

Overall health (circle one) Excellent / Good / Fair / Poor / Other: ___________________

Chief concern/diagnosis (approx. date): ______________________________________

____

First major symptom involved (approx. date): __________________________________

____

Please describe all symptoms including dates of changes (use separate sheet if needed):

____________________ ____

____

Secondary concern/diagnosis (approx. date) : __________________________________

____

Major symptom involved (approx. date): ______________________________________

____

Bowel Habits (include color, size, frequency, shape): ___________________________

____

Do you have any allergies? (food, medication or other): _________________________

____

List any major illnesses (with approx. dates):__________________________________

____

List any surgery or operations (with approx. dates): ____________________________

____

Past accidents or injuries (with approx. dates):_________________________________

____

List any prescriptions and/or over the counter medications past and present (use separate sheet if needed): ____

____

Nutritional supplements you are taking: ______________________________

____

Are you currently using essential oils? Yes/No (please list):__________________

____

What do you do for pain? ______________________________________

____

Are you on or have you ever taken birth control? Y____ N____ If yes, what form and how long? ___________

Are you pregnant, trying to get pregnant, or breastfeeding? Y ____ N ____ If yes, indicate which one: __________

Have you had any miscarriages? ______If yes, how many? ________

(with approx. dates):______________________________________

Are you right or left hand dominant? ___________

Do you wear a Fitbit or Apple watch? Y____N____

Are you currently under the care of a physician? Y ____ N ____

Are you currently under the care of any alternative health care providers (i.e. acupuncture, chiropractor, etc.)? Y ___ N ___

Do you or have you ever smoked? Y____ N____ If yes, indicate how much: _________

Current? Y_____ N_____

Do you or have you ever vaped? Y____ N____ If yes, indicate how much: ___________

Current? Y_____ N______

Do you or have you ever used CBD? Y____ N____ If yes, indicate what form and how much: __________________________ Current? Y_____ N_____

Do you use any recreational drugs? Y ___ N ____ If yes, indicate how much: ________

On a scale of 1-10 (low to high), how would you rate your stress level? _____________

Have you ever had a root canal? Yes/ No How many? ____________________

Do you have any amalgam/silver filings? Yes/ No How many? _______________

Have you ever had any amalgam/silver fillings removed? Y ___ N ___

Any family history of serious illnesses? (circle those which apply) Cancer / Diabetes / Heart / Other: ____

Family Life:

Marital Status: S M D W Name of Spouse: ______________________

Describe health of spouse: _______________ Number of children if any: ___

Name of Child	Age	Sex	Any physical conditions or concerns?
____________________________	_____	M/F	_____________________________________
____________________________	_____	M/F	_____________________________________
____________________________	_____	M/F	_____________________________________
____________________________	_____	M/F	_____________________________________

List any past traumas or shocking events in your lifetime (with approx. dates): _______

____

____

____

Health Habits/Lifestyle:

Daily Schedule/Activities (include work/profession): _________________________________

____

Daily Physical exercise/movement (how often): ____________________________________

____

Diet/Eating Habits (record 1 day of eating here) :___________________________________

____

____

For how long have you had the diet described above? ______________________________

Are you a vegetarian or vegan? Y ___ N ___ If yes, please note: ______________________

How much water do you drink daily? ____

What else do you drink? ____

Coffee? Y ___ N ___ Alcohol? Y ___ N ___ Energy drinks? Y ___ N ___

Describe any physical stressors you have in your life (ex: lifting at job, exercise, daily movement, etc):

____

____

Describe any emotional stressors you have in your life (ex. family, friends, coworkers, stressful situations, etc.):

____

____

What are your wishes for your health?

____

____

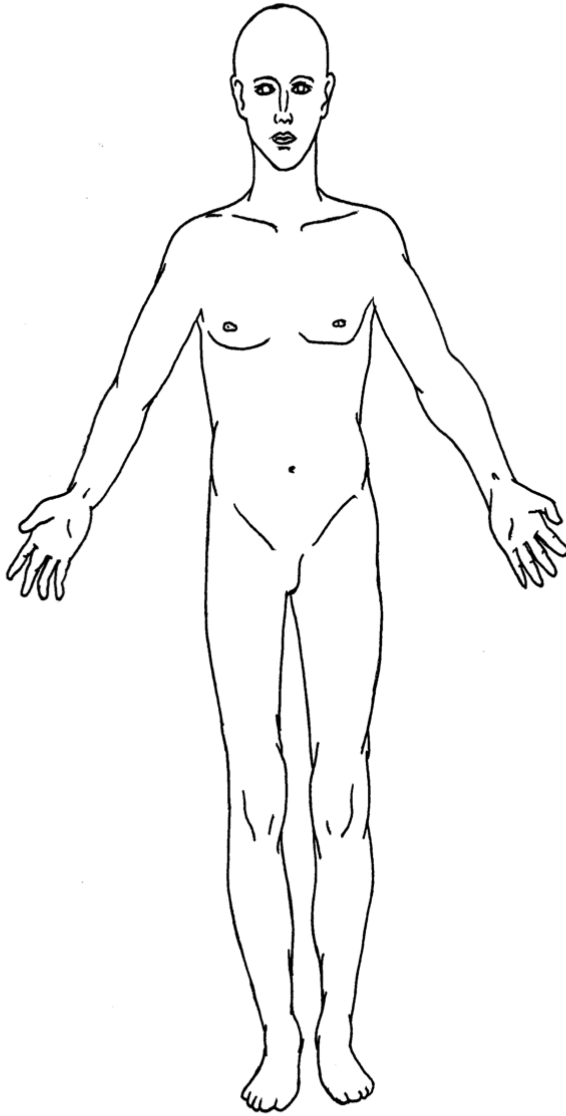
____

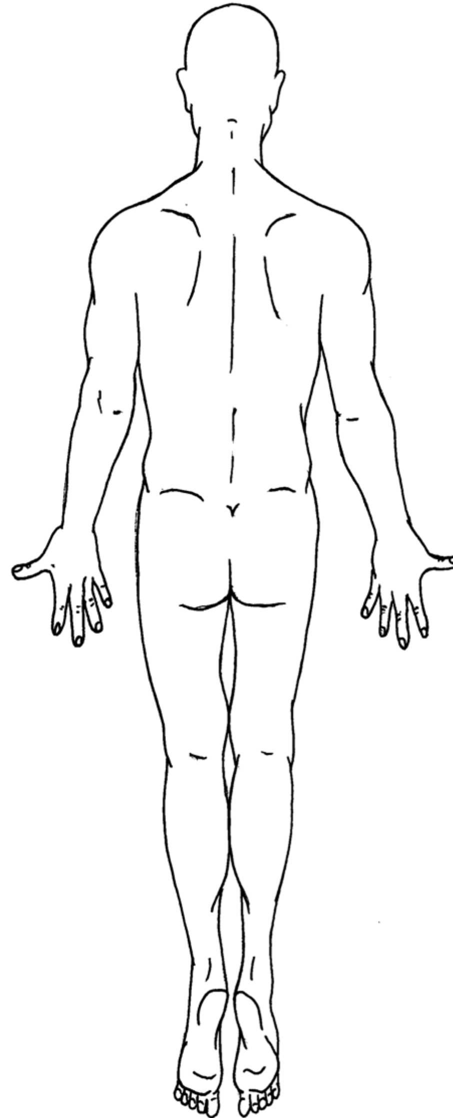
Office Use Only:

nutritionworks
holistic health

Name: ____ **Date:** __________

Please circle any scars on your body including tattoos, piercings, surgeries, accidents, etc.





Notes:

Symptom Survey

Name: Date:

Instructions: Circle ONLY the number that applies to you. Leave blank if symptom DOES NOT apply.

1	**MILD** symptom (occurs rarely)
2	**MODERATE** symptom (occurs several times a month)
3	**SEVERE** symptom (occurs almost constantly)

GROUP 1

No.	Rating	Symptom
1.	1 2 3	Acid foods upset
2.	1 2 3	Get chilled often
3.	1 2 3	"Lump" in throat
4.	1 2 3	Dry mouth, eyes, nose
5.	1 2 3	Pulse speeds after meal
6.	1 2 3	Keyed up, fail to calm
7.	1 2 3	Gag occasionally
8.	1 2 3	Unable to relax, startle easily
9.	1 2 3	Extremities cold, clammy
10.	1 2 3	Strong light irritates
11.	1 2 3	Occasionally weak urine flow
12.	1 2 3	Heart pounds after retiring
13.	1 2 3	"Nervous" stomach
14.	1 2 3	Appetite reduced occasionally
15.	1 2 3	Cold sweats often
16.	1 2 3	Get heated easily
17.	1 2 3	Nerve discomfort
18.	1 2 3	Staring, blink little
19.	1 2 3	Sour stomach frequent

GROUP 2

No.	Rating	Symptom
20.	1 2 3	Joint stiffness after arising
21.	1 2 3	Muscle, leg, toe cramps at night
22.	1 2 3	"Butterfly" stomach, cramps
23.	1 2 3	Eyes or nose watery
24.	1 2 3	Eyes blink often
25.	1 2 3	Eyelids swollen, puffy
26.	1 2 3	Indigestion soon after meals
27.	1 2 3	Always seem hungry, feel "lightheaded" often
28.	1 2 3	Digestion rapid
29.	1 2 3	Vomit occasionally
30.	1 2 3	Hoarseness frequent
31.	1 2 3	Uneven breathing
32.	1 2 3	Pulse slow
33.	1 2 3	Gagging reflex slow
34.	1 2 3	Difficulty swallowing
35.	1 2 3	Temporary constipation or diarrhea
36.	1 2 3	"Slow starter"
37.	1 2 3	Get "chilled"
38.	1 2 3	Perspire easily
39.	1 2 3	Sensitive to cold
40.	1 2 3	Upper respiratory challenges

GROUP 3

No.	Rating	Symptom
41.	1 2 3	Eat when nervous
42.	1 2 3	Excessive appetite
43.	1 2 3	Hungry between meals
44.	1 2 3	Irritable before meals
45.	1 2 3	Get "shaky" if hungry
46.	1 2 3	Fatigue, eating relieves
47.	1 2 3	"Lightheaded" if meals delayed
48.	1 2 3	Fatigue in afternoon
49.	1 2 3	Heart palpitates if meals missed or delayed
50.	1 2 3	Overeating sweets upsets
51.	1 2 3	Awaken after few hours sleep, hard to get back to sleep
52.	1 2 3	Crave candy or coffee in afternoon
53.	1 2 3	Moods of "blues" or melancholy
54.	1 2 3	Craving for sweets or snacks

GROUP 4

No.	Rating	Symptom
55.	1 2 3	Hands and feet go to sleep easily, numbness
56.	1 2 3	Sigh frequently, "air hunger"
57.	1 2 3	Aware of "breathing heavily"
58.	1 2 3	High-altitude discomfort
59.	1 2 3	Open windows in closed room
60.	1 2 3	Immune system challenges
61.	1 2 3	Afternoon "yawner"
62.	1 2 3	Get "drowsy" often
63.	1 2 3	Swollen ankles worse at night
64.	1 2 3	Muscle cramps, worse during exercise, get "charley horse"
65.	1 2 3	Difficulty catching breath, especially during exercise
66.	1 2 3	Tightness or pressure in chest, worse on exertion
67.	1 2 3	Skin discolors easily after impact
68.	1 2 3	Tendency to anemia
69.	1 2 3	Noises in head or "ringing in ears"
70.	1 2 3	Fatigue upon exertion

GROUP 5

No.	Rating	Symptom
71.	1 2 3	Dizziness
72.	1 2 3	Dry Skin
73.	1 2 3	Burning feet
74.	1 2 3	Blurred vision
75.	1 2 3	Itching skin and feet
76.	1 2 3	Hair loss
77.	1 2 3	Occasional skin rashes
78.	1 2 3	Bitter, metallic taste in mouth in morning
79.	1 2 3	Occasional constipation
80.	1 2 3	Worrier, feels insecure
81.	1 2 3	Nausea occasionally after eating
82.	1 2 3	Greasy foods upset
83.	1 2 3	Stools light-colored
84.	1 2 3	Skin peels on foot soles
85.	1 2 3	Discomfort between shoulder blades
86.	1 2 3	Occasional laxative use
87.	1 2 3	Stools alternate from soft to watery
88.	1 2 3	Sneezing attacks
89.	1 2 3	Dreaming, nightmare-type bad dreams
90.	1 2 3	Bad breath (halitosis)
91.	1 2 3	Milk products cause upset
92.	1 2 3	Sensitive to hot weather
93.	1 2 3	Burning or itching anus
94.	1 2 3	Crave sweets

GROUP 6

No.	Rating	Symptom
95.	1 2 3	Loss of taste for meat
96.	1 2 3	Lower bowel gas several hours after eating
97.	1 2 3	Burning stomach sensations, eating relieves
98.	1 2 3	Coated tongue
99.	1 2 3	Pass large amounts of foul-smelling gas
100.	1 2 3	Indigestion ½-1 hour after eating maybe up to 3-4 hours after
101.	1 2 3	Watery or loose stool
102.	1 2 3	Gas shortly after eating
103.	1 2 3	Stomach "bloating"

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Symptom Survey - continued

GROUP 7A

104. 1 2 3 Difficulty sleeping
105. 1 2 3 On edge
106. 1 2 3 Can't gain weight
107. 1 2 3 Intolerance to heat
108. 1 2 3 Highly emotional
109. 1 2 3 Flush easily
110. 1 2 3 Night sweats
111. 1 2 3 Thin, moist skin
112. 1 2 3 Inward trembling
113. 1 2 3 Heart races
114. 1 2 3 Increased appetite without weight gain
115. 1 2 3 Pulse fast at rest
116 1 2 3 Eyelids and face twitch
117. 1 2 3 Irritable and restless
118. 1 2 3 Can't work under pressure

______

GROUP 7B

119. 1 2 3 Increase in weight
120. 1 2 3 Decrease in appetite
121. 1 2 3 Fatigue easily
122. 1 2 3 Ringing in ears
123. 1 2 3 Sleepy during day
124. 1 2 3 Sensitive to cold
125. 1 2 3 Dry or scaly skin
126. 1 2 3 Temporary constipation
127. 1 2 3 Mental sluggishness
128. 1 2 3 Hair coarse, falls out
129. 1 2 3 Tension in head upon arising wears off during day
130. 1 2 3 Slow pulse below 65
131. 1 2 3 Changing urinary function
132. 1 2 3 Sounds appear diminshed
133. 1 2 3 Reduced initiative

______

GROUP 7C

134. 1 2 3 Failing memory with age
135. 1 2 3 Increased sex drive
136. 1 2 3 Episodes of tension in head
137. 1 2 3 Decreased sugar tolerance

______

GROUP 7D

138. 1 2 3 Abnormal thirst
139. 1 2 3 Bloating of abdomen
140. 1 2 3 Weight gain around hips or waist
141. 1 2 3 Sex drive reduced or lacking
142. 1 2 3 Tendency for stomach issues
143. 1 2 3 Immune system challenges
144. 1 2 3 Menstrual disorders

______

GROUP 7E

145. 1 2 3 Dizziness
146. 1 2 3 Headaches
147. 1 2 3 Hot flashes
148. 1 2 3 Hair growth on face or body (female)
149. 1 2 3 Sugar in urine (not diabetes)
150. 1 2 3 Masculine tendencies (female)

______

GROUP 7F

151. 1 2 3 Weakness, dizziness
152. 1 2 3 Tired throughout day
153. 1 2 3 Nails weak, ridged
154. 1 2 3 Sensitive skin
155. 1 2 3 Stiff joints
156. 1 2 3 Perspiration increase
157. 1 2 3 Bowel discomfort
158. 1 2 3 Poor circulation
159. 1 2 3 Swollen ankles
160. 1 2 3 Crave salt
161. 1 2 3 Areas of skin darkening
162. 1 2 3 Upper respiratory sensitivity
163. 1 2 3 Tiredness
164. 1 2 3 Breathing challenges

______

GROUP 8

165. 1 2 3 Muscle weakness
166. 1 2 3 Lack of stamina
167. 1 2 3 Drowsiness after eating
168. 1 2 3 Muscular soreness
169. 1 2 3 Heart races
170. 1 2 3 Hyperirritable
171. 1 2 3 Feeling of a band around head
172. 1 2 3 Melancholia (feeling of sadness)
173. 1 2 3 Swelling of ankles
174. 1 2 3 Change in urinary function
175. 1 2 3 Tendency to consume sweets/carbohydrates
176. 1 2 3 Muscle spasms
177. 1 2 3 Blurred vision
178. 1 2 3 Involuntary muscle action
179. 1 2 3 Numbness
180. 1 2 3 Night sweats
181. 1 2 3 Rapid digestion
182. 1 2 3 Sensitivity to noise
183. 1 2 3 Redness of palms of hands and bottom of feet
184. 1 2 3 Visible veins on chest and abdomen
185. 1 2 3 Hemorrhoids
186. 1 2 3 Apprehension (feeling that some-thing bad is going to happen)
187. 1 2 3 Nervousness causing loss of appetite
188. 1 2 3 Nervousness with indigestion
189. 1 2 3 Gastritis
190. 1 2 3 Forgetfulness
191. 1 2 3 Thinning hair

______

FEMALE ONLY

192. 1 2 3 Very easily fatigued
193. 1 2 3 Premenstrual tension
194. 1 2 3 Menses more painful than usual
195. 1 2 3 Depressed feelings before menstruation
196. 1 2 3 Painful breasts during menses
197. 1 2 3 Menstruate to frequently
198. 3 Hysterectomy/ovaries removed
199. 1 2 3 Menopausal hot flashes
200. 1 2 3 Menses scanty or missed
201. 1 2 3 Acne, worse at menses

______

MALE ONLY

202. 1 2 3 Less involved in exercise/ social activities
203. 1 2 3 Difficult to postpone urination
204. 1 2 3 Weak urinary stream
205. 1 2 3 Feeling of "blues" or melancholy
206. 1 2 3 Feeling of incomplete bowel evacuation
207. 1 2 3 Lack of energy
208. 1 2 3 Muscles in arms and legs seen softer/smaller
209. 1 2 3 Tire too easily
210. 1 2 3 Avoid activity
211. 1 2 3 Leg nervousness at night
212. 1 2 3 Diminshed sex drive

______

Please list below the five main concerns you have in order of their importance.

1.

2.

3.

4

5

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Rate each of the following situations based upon your environmental profile for the past 120 days.

213. Circle the corresponding number for questions 213a - 213f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

Question	Rating
a. How often are you exposed to strong chemicals used in your profession or home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)	0 1 2 3 4
b. How often are pesticides used in your profession or home?	0 1 2 3 4
c. How often do you have your home treated for insects?	0 1 2 3 4
d. How often are you exposed to dust, tobacco smoke, mothballs, incense or varnish in your home or office?	0 1 2 3 4
e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics?	0 1 2 3 4
f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	0 1 2 3 4

214. Circle the corresponding number for questions 214a - 214b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

Question	Rating
a. Have you noticed any negative change in your health since you moved into your home or apartment?	0 1 2 3
b. Have you noticed any change in your health since you started your new job?	0 1 2 3

215. Answer yes or no and circle the corresponding number for questions 215a - 215d below.

Question	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Any additional comments:

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