



the fertile soul

## Nutritional Counseling Intake Form

First Name (Last, First, Middle) \_\_\_\_\_ Date \_\_\_\_\_

Occupation? \_\_\_\_\_ How many hours a week do you work? \_\_\_\_\_ Commute? \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Ethnic Background/Birthplace \_\_\_\_\_

Please list your chief health concerns that you would like to improve, physical or emotional.

1- \_\_\_\_\_

2- \_\_\_\_\_

3- \_\_\_\_\_

4- \_\_\_\_\_

Do you have any allergies to food or medications? Please list.

Do you have root canals? \_\_\_ If so, how many? \_\_\_ Were you breast fed? \_\_\_

If yes for how many months? \_\_\_\_\_

Do you sleep soundly? \_\_\_ How many hours per night? \_\_\_ Have lots of dreams? \_\_\_

Do you wake in the night? \_\_\_ If yes, what time? \_\_\_\_\_

Describe any pain, stiffness or swelling in your body? \_\_\_ If yes, where? \_\_\_\_\_

Is your urine clear like water? \_\_\_ turbid or cloudy? \_\_\_ scanty? \_\_\_ yellow? \_\_\_ dark yellow? \_\_\_



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1) Favorite colors, seasons, and flavors [bitter, sweet, salty, pungent or hot, sour]:

2) Aversions to what colors, seasons, and flavors [bitter, sweet, salty, pungent or hot, sour]:

**Please circle any conditions you tend toward or are currently experiencing:**

forgetfulness	overweight	asthma	dry mouth	allergies/ hayfever
intense dreams	underweight	bronchitis	hearing loss	highly emotional
insomnia	indigestion	immune weakness	ringing in ears	bloating
restless sleep	intestinal gas	frequent colds/flu	low back pain	eye/visual problems
speech problems	diarrhea	frequent cough	dizziness	morning stiffness
confusion	constipation	skin eruptions	teeth problems	stiff neck
palpitations	weak muscles	rash/fungus	low sex drive	muscular pain
chest pains	prolapses	dry skin	knee problems	anger/ impatience
memory loss	appetite disorder	grief/sadness	aversion to cold	swellings
heart trouble	sugar craving	irritable colon	urinate often	dry/red eyes
poor circulation	hemorrhoids	shortness of	fear/insecurity	high blood press.
lack of spirit	fatigue	breath	ear infections	vertigo
joyless	worry	perfectionist	drug addiction	mood swings
spaciness	water retention	congestion	arthritis	headaches
lack of focus	ulcers	excess mucus	bone problems	depression
addictions	mouth sores		fatigue/lethargy	stress/tension

often too warm	cancer/tumors	frequent thirst	often too cold	cramps/ spasms
yellow mucus	cysts/warts	night sweats	clear mucus	paralysis/ tremor
dry stool	yeast infection	hot palm/feet	loose stools	moving pains
dark urine	dislike dampness	Tidal fevers	clear urine	dislike wind

Please list any awareness practices (calming practices: prayer, meditation, affirmation)?

Describe your daily physical exercise routine:

List any herbal, vitamin or other supplements you are currently taking:



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### Describe Current Diet

Time on current diet? \_\_\_\_\_ organic % \_\_\_\_\_ Eat late at night? \_\_\_\_\_

What percentage of your food is home-cooked? \_\_\_\_\_

Where do you get the rest from? \_\_\_\_\_

Drink with meals? \_\_\_\_\_ If so, what and how much? \_\_\_\_\_

Please indicate if you consume the following (O)ften, (S)ometimes or (N)ever:

Coffee? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Tobacco? \_\_\_\_\_ Marijuana? \_\_\_\_\_ Baking powder? \_\_\_\_\_ Yeasted

bread? \_\_\_\_\_ Margarine? \_\_\_\_\_ Shortening? \_\_\_\_\_ Commercial Donuts, pastries, candy, pop?

\_\_\_\_\_ Foods with white flour, white sugar, white rice, white pastas? \_\_\_\_\_ Deep fried foods?

\_\_\_\_\_ Dairy? \_\_\_\_\_ Meat? \_\_\_\_\_ Legumes? \_\_\_\_\_ Sea vegetables? \_\_\_\_\_ Fruit? \_\_\_\_\_

Vegetables? \_\_\_\_\_ Types of oils used \_\_\_\_\_

Do you chew your food thoroughly? \_\_\_\_\_

What foods did you eat often as a child?



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Breakfast

Lunch

Dinner

Snacks

Liquids

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What about one year ago?

Breakfast

Lunch

Dinner

Snacks

Liquids

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What's your food like these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

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