FOOD 4 LIFE NUTRITION COUNSELING

NAME:

LIST YOUR MAIN HEALTH CONCERNS	DURATION OF THE PROBLEM

SURGICAL HISTORY:

HT: **CURRENT WEIGHT:** **WEIGHT ONE YEAR AGO:**

CIRCLE OR WRITE IN ALL OF YOUR MEDICAL CONDITIONS OR DIAGNOSIS:

Arthritis – Rheumatoid/Osteo	Hypertension	Lactose Intolerance
Asthma	Hypoglycemia	Migraine
Attention Deficit Disorder	Interstitial Cystitis	Multiple Sclerosis
Celiac Disease	Irritable Bowel Syndrome	Parkinson's Disease
Chronic Fatigue Syndrome	Kidney Disease	Rhinitis
Colitis	Lactose Intolerance	Sinusitis
Crohn's Disease	Hives	Thyroid Disease
Depression	Hypertension	Ulcerative Colitis
Diabetes Type I/Type II	Hypoglycemia	Other:
Eczema	Interstitial Cystitis	Other:
Gastroesophageal Reflux	Irritable Bowel Syndrome	Other:
Hives	Kidney Disease	Other:

LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING (PLEASE INCLUDE DOSE AND FREQUENCY TAKEN):	
WHO REFERRED YOU TO OUR CLINIC:	

WHAT ARE YOUR GOALS OR DESIRES OF NUTRITION COUNSELING

IS THERE ANY OTHER INFORMATION YOU WOULD LIKE TO SHARE THAT WOULD HELP IN YOUR NUTRITIONAL CARE

Please note insurance plans can vary for nutrition coverage. We suggest you contact your insurance company to confirm coverage for nutrition services, using the following CPT codes:

97802 Initial nutrition consultation and assessment
97803 Follow-up/reassessment nutrition consultation

In the event nutrition services are not covered by your plan, please contact Natalie (extension 1003) for financial arrangements that will help you receive the nutritional care you require.

Food 4 Life Nutrition Counseling
5006 Center Street Suite U
Tacoma, WA 98409
253-284-4488

Symptom Survey

Date:	Patient Name:	Patient Signature:

In order to provide our patients with the best possible care, please fill in the following form completely. Score every symptom based on your experience over the last 30 days, or since your last Symptom Survey, whichever was most recent. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for **every symptom** listed. Total the points for each category and add all category totals to come up with the Grand Total.

SCALE OF SYMPTOM POINTS:

●○○○○ = 0 = Don't Suffer From This Ever or Almost Ever
○●○○○ = 1 = Suffered OCCASSIONALLY (less than 2 times per week), symptom **wasn't severe**
○○●○○ = 2 = Suffered FREQUENTLY (2 or more times per week), symptom **wasn't severe**
○○○●○ = 3 = Suffered OCCASSIONALLY and symptom **was severe**
○○○○● = 4 = Suffered FREQUENTLY and symptom **was severe**

Grand Total:

CONSTITUTIONAL
○○○○○ Fatigue (sluggish, tired)
○○○○○ Hyperactive (nervous energy)
○○○○○ Restless (can't relax/sit still)
○○○○○ Sleepiness During Day
○○○○○ Insomnia at Night
○○○○○ Malaise (Feeling Lousy)
_____ TOTAL (0-24)

EMOTIONAL/MENTAL
○○○○○ Depression
○○○○○ Anxiety
○○○○○ Mood Swings
○○○○○ Irritability
○○○○○ Forgetfulness
○○○○○ Lack of concentration/focus
_____ TOTAL (0-24)

HEAD/EARS

NASAL/SINUS
○○○○○ Post Nasal Drip
○○○○○ Sinus Pain
○○○○○ Runny Nose
○○○○○ Stuffy Nose
○○○○○ Sneezing
_____ TOTAL (0-20)

MOUTH/THROAT
○○○○○ Sore Throat
○○○○○ Swollen Throat
○○○○○ Swelling of Lips/Tongue
○○○○○ Gagging/Throat Clearing
○○○○○ Canker Sores
_____ TOTAL (0-20)

LUNGS
○○○○○ Wheezing
○○○○○ Chest Congestion

MUSCULOSKELETAL
○○○○○ Joint Pains/Aching
○○○○○ Stiff Joints
○○○○○ Muscle Aches
○○○○○ Stiff Muscles
_____ TOTAL (0-16)

CARDIOVASCULAR
○○○○○ Irregular Heartbeat
○○○○○ High Blood Pressure
_____ TOTAL (0-8)

DIGESTIVE
○○○○○ Heartburn/Reflux
○○○○○ Stomach Pains/Cramps
○○○○○ Intestinal Pains/Cramps
○○○○○ Constipation
○○○○○ Diarrhea
○○○○○ Bloating Sensation

○○○○○ Migraine (any kind) ○○○○○ Headache (other than Migraine) ○○○○○ Earache ○○○○○ Ear Infection ○○○○○ Ringing in Ear ○○○○○ Itchy Ears ○○○○○ Discharge From Ears _____ TOTAL (0-28) **SKIN** ○○○○○ Blemishes, Acne ○○○○○ Rashes, Hives ○○○○○ Eczema ○○○○○ “Rosy” Cheeks _____ TOTAL (0-16)	○○○○○ Dry Cough ○○○○○ Wet Cough _____ TOTAL (0-16) **EYES** ○○○○○ Red or Swollen Eyes ○○○○○ Watery Eyes ○○○○○ Itchy Eyes ○○○○○ Dark Circles" or "Bags" _____ TOTAL (0-16) **GENITOURINARY** ○○○○○ Increased Urinary Frequency ○○○○○ Painful Urination _____ TOTAL (0-8)	○○○○○ Gas (of Any Kind) ○○○○○ Nausea, Vomiting ○○○○○ Painful Elimination _____ TOTAL (0-36) **WEIGHT MANAGEMENT** _____ **Record Actual Weight** ○○○○○ Fluctuating Weight ○○○○○ Food Cravings ○○○○○ Water Retention ○○○○○ Binge Eating or Drinking ○○○○○ Purging (all methods) _____ TOTAL (0-20)