Beve KINDBLADE
NUTRITIONIST

Medical History Form

Please check any of the following medical conditions you currently have or have been treated for in the past:

- ☐ ADD or ADHD
- ☐ Allergies (environmental, food, seasonal)
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Asthma/Breathing Issues
- ☐ Bi-polar issues
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Colon Issues
- ☐ Depression
- ☐ Diabetes – Type 1 or Type 2 or pre-diabetic or Gestational Diabetes (please circle)
- ☐ Digestion Issues
- ☐ Fatigue
- ☐ Fertility/Conception
- ☐ GI problems (esophagus, stomach or intestines)
- ☐ Gluten Intolerance
- ☐ Headaches
- ☐ Heartburn
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Hypertension – High Blood Pressure
- ☐ Hypotension – Low Blood Pressure
- ☐ IBS/Crohn's Disease/Colitis
- ☐ Immune issues
- ☐ Kidney Stones
- ☐ Kidney Disease or Issues
- ☐ Liver Disease or Issues
- ☐ Memory Problems
- ☐ Menopause
- ☐ Mood Swings
- ☐ Neurological Condition
- ☐ Osteoporosis or osteopenia
- ☐ PCOS
- ☐ Reflux disease or GERD
- ☐ Sleep Issues
- ☐ Weight Gain or Weight Loss
- ☐ Other:_____

2) Are you allergic to any medications? If so, which ones?

3) Are you allergic to any foods, beverages or specific ingredients related to food? If so, which ones?

4) Please list all prescription medications that you are currently taking below:

5) Please list all vitamin, mineral, herbal and botanical supplements/medicines (with amounts taken and how often):

6) What are your reasons for visiting today?

7) What are your health and wellness goals?

8) How would you rate your stress level on a scale of 1 to 10? (1=low; 10=high) ☐

9) What type of activities, hobbies and exercise are you involved in daily?

10) Is stress a concern for you at the present time? ☐

Please check all of the following integrative medicine services that you have used in the past or currently use:

- ☐ Acupuncture
- ☐ Botanical Medicine
- ☐ Chiropractic
- ☐ Counseling
- ☐ Dance Therapy/Pilates
- ☐ Homeopathic Medicine
- ☐ Hypnotherapy
- ☐ Massage
- ☐ Meditation
- ☐ Naturopathic Medicine
- ☐ Nutrition Counseling
- ☐ Strength/Flexibility Training
- ☐ Other

_____

- ☐ **Height:**_____
- ☐ **Current Weight:**_____

Date:_____

Name:_____

Patient Signature:

_____

Print