Catherine Bogolub
Integrative Physician Nutritionist

Initial Consult Intake

Date:

Name:

Age/Date of Birth:

What is the reason for your visit today?_____

_____

When did it begin to concern you?

_____

_____

Have you been diagnosed by a physician? If so, what is the diagnosis?

_____

_____

List your health concerns, with the most important one first:

1._____

_____

2._____

_____

3._____

_____

4._____

_____

5._____

_____ _____

Current Diet: Are you following a specific diet?

_____

_____

List any foods you are currently avoiding.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any prescriptions or over the counter medications and dosages you are taking.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any supplements such as vitamins, minerals, herbs, enzymes, or amino acids you are currently taking.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any allergies and reactions

_____

_____

Current Social Habits

Do you smoke? Yes No Frequency_____Amount_____

Have you ever smoked? Yes No Frequency_____Amount_____

Do you use alcohol? Yes No Frequency_____Amount_____

Do you use recreational drugs? Yes No Frequency_____Amount_____

IV drug use? Yes No Frequency_____Amount_____

Personal History (please describe)

Addictions_____

_____

Alcoholism_____

_____

Arthritis_____

_____

Asthma_____

_____

Cancer_____

_____

ChronicFatigue_____

_____

Depression_____

_____

Diabetes_____

_____

DigestiveProblems_____

_____

Fibromyalgia_____

_____

Gallbladder_____

_____

HeartDisease_____

_____

Hepatitis_____

_____

_

High Blood Pressure_____

_____

HighCholesterol_____

_____

ImmuneDisorder_____

_____

KidneyDisease_____

_____

LowBloodPressure_____

_____

MentalHealth_____

_____

SeizureDisorder_____

_____

SleepDisorder_____

_____

Stroke_____

_____

ThyroidDisease_____

_____

VaricoseVeins_____

_____

BruiseEasily_____

_____

Pregnancy_____

_____

Other _____

Surgeries: type, findings, date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History –Identify Family Member

Addiction_____

_____

Alcoholism_____

_____

Allergies_____

_____

Arthritis_____

_____

Asthma_____

_____

Cancer_____

_____

LungDisease_____

_____

Depression_____

_____

Diabetes_____

_____

DigestiveProblems_____

_____

HeartDisease_____

_____

HighBloodPressure_____

_____

HighCholesterol_____

_____

KidneyDisease_____

_____

LowBloodPressure_____

_____

MentalHealth_____ Suicide_____

_____ _____

Smoker_____ ThyroidDisease_____

_____ _____

Stroke_____ Other_____

_____ _____

Family Member Health Status

Family Member	Living/Age	Deceased/Age	Cause
Mother			
Father			
Sibling M / F			
Sibling M / F			
Sibling M / F			

Significant Emotional, Social and Physical Life Events – please check all that apply

☐ Births ☐ Deaths ☐ Weddings
☐ Divorce ☐ Illness ☐ Job Change
☐ Unemployment ☐ Moving ☐ Abuse
☐ Finances ☐ Accidents ☐ Retirement

Are you currently employed?_____ What is your job?_____

Do you like your job? _____

How many hours do you typically work in a week? _____

What is your marital status? ___single ____married ____ partnered ___divorced___widowed

Who lives in your household? _____

If you have children, what are their ages? _____

Do you have pets? If yes, what kind?_____

Do you have periods where you feel overloaded or burned out? Yes____ No _____

Do you feel in control of the stresses in your life? Yes ____ No _____

Do you have a daily stress management technique? Yes ____ No _____

Describe your daily practice._____

How many social groups do you belong to?
Describe._____

Who could you reach out to for help in a
crisis?_____

Do you experience a full range of emotions?_____

Is there any emotion(s) that you feel inappropriately or
excessively?_____

Do you have a safe living
situation?_____

Sleep Pattern

Are you satisfied with your sleep pattern? Yes ____ No ____

How many hours of sleep do you get nightly?_____

How many times do you wake up nightly? _____

Are you a loud snorer?_____

Do you take regular naps?_____

Spirituality (HOPE Screening)

Hope

What are your sources for hope, strength and comfort?

_____

What do you hold onto during difficult times?

_____

What sustains you and keeps you going?

_____

Organized Religion

Are you part of a religious or spiritual community?

Does it help you? How?_____

What parts of your religion are helpful and not so helpful to you?

_____

Personal Spirituality

Do you have any personal spiritual beliefs that are independent of a religion?_____

What spirituality practices to you find most helpful to you personally?_____

Effects on Medical Care

Has being sick affected your ability to do things that usually help you spiritually?

_____

Is there anything I can do to help you access the resources that usually help you?

_____

Are there any specific practices or restrictions I should know about in providing your medical care?

_____

Nutrition and Diet and Exercise

Are you satisfied with your weight?

_____

Do you eat regular meals?

_____

Do you consume caffeine?

_____

Do you feel in control of your eating habits?

_____

Do you have cravings?_

_____

How often do you exercise?

_____

Do you feel satisfied with your exercise habits?

_____

Type(s) of Exercise:

_____

_____

Generally how would you describe your health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous experience with complementary, alternative or holistic therapy:

☐ Acupuncture
☐ Biofeedback
☐ Chiropractic
☐ Energy Healing
☐ Hypnosis
☐ Massage

☐ Meditation/Mindfulness
☐ Movement therapy (yoga, tai chi)
☐ Guided Imagery
☐ Herbal Remedies
☐ Other_____