# *health equations*

# INTAKE FORM

Name _____ Date _____

Occupation _____ Age _____ Sex _____ D.O.B. _____

Blood Pressure _____ Pulse _____ Blood Type _____

***Please circle words or check boxes for whatever applies to you; fill in blanks.***

◆ **Water, Salt, Energy, Stress:**

My current salt use is- *low, moderate, heavy, by taste*

I have never used much or any salt- *True* or *False*

I previously used salt more than now- *True* or *False*

I have followed a low salt diet for _____ years.

Average energy level on a scale of 1 to 10 _____

Number of glasses of water each day _____

I crave salt and/or salty foods- *True* or *False*

I have unquenchable thirst- *True* or *False*

I sweat ... *a-lot, moderately, very little, not-at-all*

Average stress level on a scale of 1 to 10 _____

◆ **Family History:** ❑ cardiovascular disease ❑ adult onset diabetes ❑ thyroid disease ❑ osteoporosis

◆ **Milk Intolerance:** (circle one) **Y N**

◆ **Number of TOTAL pounds lost throughout your life dieting** _____.

◆ **Number of silver/amalgam fillings, currently** _____, **removed** _____.

◆ **Number of root canals, currently** _____, **removed** _____.

◆ **Exposure to heavy metals, chemicals, dust, infections, radiation, plastics:** _____

_____

◆ ***Women Only***

Number of childbirths _____

Number of years nursing _____

Menstrual-related symptoms _____

_____

Perimenopausal years _____

Menopausal years _____

Menopausal symptoms _____

_____

◆ ***Men Only***

Prostate enlargement? **Y N**

Elevated PSA? **Y N**

Urination difficulties? **Y N**

Nighttime urination? **Y N**

Sexual difficulties? **Y N**

## FOOD DIARY

Please indicate the NUMBER OF SERVINGS PER WEEK you have of each of the following foods:

beef_____

poultry
white_____
dark_____

lamb_____

fish_____

pork_____

soy "milk"_____

tofu/soy products_____

milk_____ %fat____

yogurt _____ %fat____

cottage cheese____ %fat____

eggs (# per week)_____

butter_____
(sticks per week)

cheese _____
(ounces per week)

fresh fruit _____

fresh vegetables _____

breads, cereals, grains and pastas:
~refined/processed_____
~whole grain _____

legumes_____ seeds _____

nuts/nutbutters _____

oils, *please specify kind(s)* *weekly servings*

_____ _____

_____ _____

_____ _____

protein powder, *specify kind - weekly*

_____ _____

sweets (cookies, cakes, sodas, candy, ice cream, *etc.*)_____

caffeine: tea_____ coffee_____

dark soda_____ light soda_____

wine_____ beer_____ liquor_____

How much *calcium* do you supplement daily? _____ *mg*
For how long? *(circle one)* weeks, months, years

How much *magnesium* do you supplement daily? _____ *mg*
For how long? *(circle one)* weeks, months, years

## EXERCISE

Please describe the type, frequency and duration of exercise.

_____

_____

_____

## For Calculation of %BODY FAT

Height _____ Weight _____

Abdomen Measurement at Navel _____ inches

***(Women only)*** Hips Measurement at the Widest Point _____ inches

***(Men only)*** Wrist Measurement _____ inches

## DIGESTION INDICATOR CHECKLIST

- ❑ food allergies/intolerances: _____
  _____
- ❑ crave specific foods: _____
  _____
- ❑ avoid specific foods: _____
  _____
- ❑ low fat or no animal fat
- ❑ low or no carbohydrates
- ❑ burning sensation in stomach which eating relieves
- ❑ burping
- ❑ acid indigestion, sour stomach, heartburn
- ❑ tight/full upper abdomen after eating
- ❑ pale stools
- ❑ crave fats
- ❑ gall bladder attacks or stones
- ❑ abdominal bloating / distention
- ❑ flatulence (gas)
- ❑ coated tongue
- ❑ diarrhea
- ❑ constipation / incomplete evacuation
- ❑ alternating diarrhea and constipation
- ❑ loss of taste for meat
- ❑ always hungry
- ❑ low blood sugar ❑ high blood sugar

## SLEEP CHECKLIST

Number of hours _____

Sleep quality:
❑ poor ❑ good
❑ fair ❑ excellent

- ❑ awake during night at _____ a.m.
- ❑ awake rested
- ❑ difficulty falling asleep
- ❑ awake too early
- ❑ frequent snoring
- ❑ another person has witnessed you stop breathing during sleep

**PLEASE INCLUDE A LIST OF ALL SUPPLEMENTS AND MEDICATIONS YOU ARE CURRENTLY TAKING. BE SURE TO LIST THE DOSE AND FREQUENCY FOR EACH ONE.**