Main Street Nutrition Health History

Name_____ **Date**_____ _

Address_____ **City**_____ **State**_____ **Zip**_____

Phone (home)_____ **(work)**_____ **(cell)**_____

Occupation_____ **Date of Birth** _____

Blood Type (if known)_____ **Height**_____ **Weight**_____

How were you referred to MSN? _____

Last physician or health practitioner seen?_____

Your current health problems:
What is the **main** reason for your visit today? If you have a specific health condition please describe in detail. Please note the first time you noticed your condition, and describe carefully any factors you suspect may have played a role in its onset and continuation.

List in order of importance other health problems that are troubling you:

1)_____ & length of time_____

2)_____ & length of time_____

3)_____ & length of time_____

How long has your **main** problem been troubling you? _____

Is your **main** problem getting (better, worse, same) and for how long? _____

Do you have any blood relative who has/had any of the following? Please circle:

Allergies	Asthma	Cancer	Diabetes
Anemia	Seizures	Thyroid	Heart disease
Arthritis	Depression	Eczema	Genetic disease
Ulcers	Cataracts	Osteoporosis	Chemical dependency

Health insurance is a method of reimbursing the client for fees paid to the healthcare provider. It is not a substitute for payment It is your responsibility to pay for services when received You will be given a receipt that you may submit directly to your insurance company Your insurance company will then pay you for any amounts they cover We are not able to bill the insurance companies for you

Main Street Nutrition Health History

Medical Information

Please check all that apply:

___ Headaches
___ Shooting pain in hand
___ Multiple Sclerosis
___ Pain in hip
___ Tingling in hands/arms
___ Cold hands
___ Bowel obstruction
___ Chest pain/angina
___ Shortness of breath
___ High triglycerides
___ High cholesterol
___ Heart palpitations
___ Heart attack
___ Hypertension
___ Hypotension
___ Depression
___ Dizziness
___ Fainting spells
___ Loss of balance
___ Ringing in ears
___ Seizures
___ Hypoglycemia

___ Muscle spasms
___ Liver trouble
___ Gall bladder trouble
___ Alcoholism
___ Intestinal gas
___ Cancer/tumors
___ Bad breath
___ Kidney trouble
___ Bladder trouble
___ Diabetes
___ Sleeping problems
___ Painful joints
___ Swollen joints
___ Arthritis
___ Nervous stomach
___ Stomach troubles
___ Stomach ulcers
___ Inner tension
___ Allergies
___ Infections
___ Eczema/Psoriasis
___ Swollen lymph glands

___ Cold sweats
___ Sinus trouble
___ Loss of smell
___ Hay Fever
___ Asthma/Emphysema
___ Chemical exposure
___ Loss of taste
___ Tightness in throat
___ Throat inflammation
___ Thyroid trouble
___ Face flushed
___ Fractures
___ Slipped disc
___ Fatigue
___ Anemia
___ Swollen ankles
___ Crying spells
___ Anorexia
___ Bulimia
___ Heartburn
___ Hiatal hernia
___ Parasites

Please list all supplements you are currently taking:

Type/Name Brand	Dosage

Please circle any of the following medications you are presently taking:

Allergy
Antacids
Anti-inflammatory
Antibiotic/anti-fungal
Antidepressants
Anti-diabetic/Insulin
Aspirin

Chemotherapy
Cortisone
Heart
Blood pressure
Hormones
Laxatives
Lithium

Oral Contraceptives
Pain
Radiation
Recreational Drugs
Relaxants
Sleeping Pills
Thyroid

Ulcer
Other _____
_____
_____
_____
_____
_____

Main Street Nutrition Health History

Please check all that apply:

___ Indigestion, food repeats after meals
___ Excessive burping, belching, bloating after meals
___ Stomach spasms & cramping during or after eating
___ Sensation that food just sits in your stomach
___ Bad taste in your mouth
___ Skip meals or eat erratically

___ Feel hungry 1 or 2 hours after a meal
___ Stomach pain, burning, aching 1-4 hours after meals
___ Stomach pain, burning and/or aching relieved by eating food, drinking carbonated beverage, cream, milk or antacids
___ Burning sensation in lower part of your chest
___ Digestive problems subside with rest or relaxation
___ Eating spicy and fatty foods, chocolate, coffee, alcohol, citrus or causes stomach to ache or burn
___ Feel a sense of nausea when you eat
___ Pain when swallowing food or beverage

___ Indigestion, fullness or tension in abdomen 2-4 hours following a meal
___ Consistency or form of stool changes
___ Stool odor is embarrassing
___ Undigested food in your stool
___ Diarrhea
___ Constipation
___ Stool is hard and dry
___ Discomfort, pain or cramps in your colon
___ Alternate between constipation and diarrhea
___ Pain at night that may move to back or right shoulder
___ Bitter fluid repeats after eating
___ Abdominal discomfort or nausea after eating rich, fried or fatty foods
___ Throbbing temples and/or dull pain in forehead associated with overeating
___ Unexpected itchy skin worse at night
___ Bruise easily

___ Cold/chilled hands or feet for no apparent reason
___ Upper eyelids look swollen
___ Muscles weak, cramp and/or tremble
___ Forgetfulness
___ Feels like heart beats slowly
___ Reaction time seems slowed down
___ Feel sluggish or slow moving
___ Constipated
___ Dryness, discoloration of skin and/or hair
___ Voice becoming deeper recently
___ Thick, brittle nails
___ Increased loss of hair
___ Weight gain for no apparent reason
___ Swelling of the neck
___ Outer third of eyebrow is thinning

___ Lingering mild fatigue after exertion or stress
___ Craving for salty foods
___ Sensitive to weather changes or surroundings
___ Dizzy when rising from a kneeling position
___ Dark bluish or black circles under your eyes
___ Catch colds or infections easily

When you go without food for an extended period of time do you experience any of the following symptoms:
___ Sense of weakness
___ Anxiety
___ Tingling sensation in hands
___ Heart palpitations
___ Shaky, jittery, hands trembling
___ Profuse sweating an/or skin feels clammy
___ Wake up at night feeling restless
___ Agitation, easily upset, nervous
___ Forgetfulness
___ Dizzy or faint
___ Confused or disorientated

___ Frequent urination day or night
___ Unusual thirst- feel like you cannot drink enough water
___ Unusual hunger
___ Vision blurs
___ Tingling or numbness in feet
___ Sense of lethargy or drowsiness during the day
___ Sores heal slowly
___ Loss of hair on legs
___ Eating starchy foods causes weight gain

___ Feel jittery
___ First effort of day causes pain, pressure, and tightness around chest
___ Difficulty catching breath, especially during exercise
___ Sensation of heart beating too quickly, slowly, or irregularly
___ Swelling in feet, ankles, or legs
___ Lack of strength, ie weak grip

___ Muscle pain at rest
___ Cramp-like pains in ankles, calves or legs
___ Numbness, tingling and prickling sensation in hands or feet
___ Feel worse standing, legs get heavy and fatigued
___ Leg discomfort relieved by elevating legs
___ Fingers & toes numb in cold weather, even while protected
___ Decline in ability to make decisions, focus, or follow directions

___ Family, friends, work, or activities no longer hold interest
___ Does life look hopeless
___ Sleep problems, too much or too little
___ Changes in your appetite and weight
___ Lately you noticed inability to think clearly or concentrate
___ Difficulty making decisions
___ Would you consider yourself a nervous person?
___ Easily agitated
___ Are you keyed up and jittery?
___ Do you find yourself sighing a lot?
___ Do frightening thoughts keep coming back into your mind?
___Do you break out in a cold sweat?
___ Butterflies in your stomach, nausea and/or diarrhea

___ Eyes water or tear
___ Mucous discharge from eyes
___ Is your nose continually congested?
___ Are you prone to loud snoring?
___ Nosebleeds
___ Hoarse voice
___ Do you have to clear your throat?
___ Do you feel a choking lump in your throat?
___ Frequent colds
___ Do infections settle in your lungs?

___ Do you struggle with shortness of breath?
___ Do you cough up lots of phlegm?
___ Do you wheeze?
___ Do you have severe soaking sweats at night?
___ Eyes, ears, nose, throat and lung symptoms associated with specific foods like dairy or wheat products
___ Eyes, ears, nose, throat and lung symptoms associated with seasonal change

___ Involuntary loss of urine when you cough, or strain during activity
___ Pain or burning when urinating
___ Rarely feel the urge to urinate
___ Urge to urinate less than every two hours, day or night
___ Sense of water retention
___ Sudden urge to void causes involuntary loss of urine

Main Street Nutrition Health History

___ Localized bone pain
___ Hands, feet or throat get tight, spasm or feel numb
___ Upper or lower back pain
___ Shins hurt during exercise
___ Stiff in morning upon arising
___ Joint swelling, pain or stiffness involving one or more joints
___ Joints hurt when moving or carrying weight
___ Difficulty standing up from a sitting position
___ Shooting, aching, tingling pain down the back of the leg
___ Injure, strain or sprain easily
___ Muscles stiff, tense, sore and/or ache
___ Burning, throbbing, shooting, or stabbing muscle pain
___ Specific points on body feel sore when pushed
___ Feel unrefreshed upon awakening
___ Muscle twitch or tremor- eyelids, thumb or calf muscle
___ Legs move during sleep
___ Feelings of "pins and needles" in thumb and first 3 fingers

___ Difficulty absorbing new information
___ Tend to forget things
___ Trouble thinking or concentrating
___ Easily distracted

___ Inability to sit still for any length of time
___ Difficulty finishing tasks
___ Low tolerance for stress

Men only
___ Sensation of not emptying bladder
___ Need to stop & start several times while urinating
___ Find it difficult to postpone urine
___ Weak urinary stream
___ Need to push or strain to begin urinating
___ Dripping after urination
___ Urge to urinate several times per night

Women only
Do you experience any of the following within 3 days to 2 weeks prior to menstruation:
___ Anxious, irritable or restless
___ Numbness, tingling in hands or feet
___ Anger easily
___ Aggressive toward family and/or friends
___ Abdominal bloating
___ Temporary weight gain
___ Breast tenderness, swelling
___ Appearance of breast lumps
___ Discharge from nipples
___ Nausea and/or vomiting,
___ Aches & pains (back, joints, etc)
___ Craving for sweets
___ Increased appetite or binge eating
___ Headaches
___ Being easily overwhelmed, shaky or clumsy
___ Heart pounding
___ Dizziness or fainting
___ Feelings of sadness
___ Difficulty sleeping or falling asleep

Do you experience any of the following during your period:
___ Cramping in lower abdomen or pelvic area
___ Pain is sharp and/or dull or intermittent
___ Unusual fatigue
___ Painful and/or swollen breasts
___ Scanty blood flow
___ Painful or difficult sexual intercourse
___ Low abdominal, back and vaginal pain
___ Abnormal vaginal discharge
___ Vaginal itching or burning with or without intercourse
___ Profuse or prolonged menstrual bleeding
___ Unable to get pregnant
___ Frequent infection kidney or bladder
___ Ovarian cysts
___ Absence of periods for six months or more
___ Periods occur irregularly
___ Cycles greater than 35 days
___ Bleeding occurs at ovulation
___ Acne and/or oily skin
___ Increase growth of dark facial and/or body hair
___ Length of days in cycle varies month to month
___ Skip periods

Circle if you eat, drink, or use:

Candy	Coffee	Donuts	Pastries	Junk foods	Alcohol
Chips	Sugar	Soft drinks	Diet foods	High-fat foods	Artificial Sweeteners
Cigarettes	Margarine	Salt	Ice cream	Luncheon Meats	

Diet Survey Please list everything you eat and drink for 2-3 days below:

Time	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						