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Nutrition Intake Form

*Please fill out this form. Scan and email back to DrSera@drsera.com

(Please print)

First & Last Name _____ Today's Date _____

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Email Address _____ Ht _____ Wt _____ Sex _____ Age _____ Date of Birth _____

Occupation/Employer _____ Emergency Contact (Name & Phone Number) _____

Blood Type: O+ O- A AB

Primary Care Physician (Name, Practice, Location) _____

Reproductive Endocrinologist (Name, Practice, Location) _____

How did you hear about us? (doctor, nurse, friend, website, flyer) _____

In case of a Press Event, would you be willing to share your story? D Yes D No

If YES, please check which of the following we could contact you about:

D Print/Interview D TV D Radio D Testimonial

Health History

What are the health problems for which you are seeking treatment? _____

How long have you had this condition? _____

What other forms of treatment have you sought? _____

Please list any surgeries or major health incidents (year and type) _____

Family Medical History _____

What is your primary reason(s) for seeking nutrition coaching? Please describe current condition

Please list all medications (and dosages if possible) that you are currently taking or have taken in the past 2 months (vitamins, supplements, over-the-counter medications, herbs)

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

Family History (M= Mother, F= Father, G= Grandparents, B= Brother, S= Sister, C= Children, Sp= Spouse)

_____Allergies_____Arthritis_____Cancer_____Diabetes _____Reproductive Disorders

_____Thyroid Disease_____Alcoholism_____Heart Disease_____Stroke_____Autoimmune Disease

Please indicate if you currently have or have had in the past any of the following symptoms or diagnoses:

D Acne
D Antibiotic use (extended)
D Constipation
D Depression/Anxiety
D Diarrhea
D Dry hair
D Dry skin
D Endometriosis
D Facial hair growth
D Fatigue, sluggishness
D Feel cold often
D Feel hot often
D Fibroids
D Gas/bloating
D Hair loss/thinning
D Headaches
D Heartburn
D Hot Flashes
D Hypothyroid
D Irritable Bowel Syndrome
D Irritable/depressed during menses
D Leg/muscle cramps
D Less than 1 bowel movement per day
D Menstrual clotting
D Period cramps
D Polycystic Ovarian Syndrome
D STD
D Yeast Infections

D Other, list _____

Reproductive History

Regular menses cycle? D Yes D No Date of last period _____ Clots? DYes D No

Pain or Cramping? D Yes D No Flow is D Heavy D Medium D Light Abnormal Discharge? DYes D No

Number of pregnancies _____ Number of births _____

Have you ever been on the birth control pill or any other form of hormonal contraception?

If yes, what type?_____For how long?

_____ How long have you been trying to conceive? _____

Have you sought ART previously? D Yes D No If yes, what have you done?

_____

If you have gone through in-vitro, how many eggs were retrieved and how many fertilized? _ Has you partner been tested for any fertility-related problems? DYes D No

If yes, what were the results? _____

Nutrition Information

On a scale of 1-10 (10 being extremely healthful), how do you rate your diet? _____

Please describe any current dietary restrictions that you may have _____

_____

Do you have food allergies? D Yes D No If yes, please describe _____

_____

Have you made any recent changes to your diet? DYes D No If yes, please describe _____

_____

Please specify how many of the follow you eat *per week*:

_____beans/legumes	fresh vegetables	red meat
_____butter	margarine	refined carbs (crackers, chips, pasta) _____
_____cheese	milk	sugar substitute
chicken/turkey	nut butters	sweets (dessert, candy, cookies) _____
_____fresh fruit	_____pork/ham/bacon	yogurt

Please indicate any foods that are not listed that you consume regularly

_____

Please specify how many of the follow you drink *per week*:

_____alcohol _____diet soft drinks regular soft drinks

_____

_eggs _nuts & seeds tofu/soy _fish _olive oil _____whole grains

_____ caffeinated coffee fruit juice _____regular tea (black)

__decaf coffee _____ green tea sports drinks ____diet drinks/aids

__herbal tea _____ water

Please indicate any beverages that are not listed that you consume regularly _____

_____

What is your drinking water source? D Tap D Bottled D Filtered D Reverse Osmosis D Distilled D Well

How often do you choose organic fruits and vegetables and grass-fed/cage-free animal products? _____

What foods do you crave? ___

What foods do you avoid? ___

Why? _____

Do you snack during the day? DYes D No If yeas, please describe _____

_____

How many times per week do you eat breakfast?_____Please describe your usual breakfast _____

_____

Please specify how many times you eat the following meals away from home *per week*:

_____Breakfast _____Lunch _____Dinner

Do you generally cook your own meals?_____How often?_____Do you like to cook? DYes D

No Where do you do most of your grocery shopping? _____

How would you describe most meals: D Relaxed D Rushed D Standing up in front of the TV D

Seated at the table D In the car D Alone D With family or friends

Do you feel you eat a wide variety of foods? D Yes D No D Unsure

How often do you consume sugar? D Daily D 3-4 times per week D Occasionally D Seldom/Never

Please specify which of the following are included in your diet: D Fast Food D Prepared Meals at Home D Fresh D Canned D Frozen D Boxed or Bagged D Organic D Conventional D Free-Range/Grass-Fed

Do you have good energy levels? D Yes D No D Inconsistent Does napping help or make it worse? DYes D No

Can you attribute low energy to anything in particular? D Yes D No

If yes, please specify _____

Do you consider yourself D Underweight D Overweight D Just Right Please circle:

I have / have not previously used diet or exercise to lose or gain weight.

I have / have not previously used medications or supplements to lose or gain weight. Do you diet frequently? D Yes D No Are you currently on a diet? D Yes D No

Do you, or have you ever used tobacco? D Yes D No_____# per day_____# of years if quit, when? _____

Do you drink alcohol? D Yes D No (# per day/week) Beer_/_____Wine____/____Liquor____/____

If quit, when?_ _____

Sleep Time you normally go to bed _____Fall asleep _____ Awaken for the day

How many hours of sleep do you need to feel rested?_____How many do you get? _____

Exercise Do you exercise? D Yes D No

If so, how often? D Daily D Every other day D Twice per week D Once per week D Rarely

Type of exercise? D Walk D Aerobics D Dance D Run D Bicycle D Team Sports D Yoga D Weight Lift

D Other, please specify _____

Emotional State Rate your current daily stress level (0-10) in regard to: _____Job or school _____
Divorce/Separation/Death Primary relationship Family/Parents/Children Financial _Other, please specify

What activities do you engage in to counterbalance stress in your life?_____

_____

_____

Please provide any additional information you feel might be helpful _____

_____

_____

Symptom Questionnaire*

(*Adapted from Julia Ross's book "The Diet Cure")

This questionnaire is a quick way to assess many potential root causes of clinical conditions. We use it as a springboard to develop a personalized nutrition program and, upon follow-up, to assess improvement.

Hormones **_____Total Score**

4 Premenstrual mood swings
4 Premenstrual or menopausal food cravings

4 Irregular periods or migraines
3 Experienced miscarriage, abortion or infertility
4 Use(d) birth control pills or other hormone medication
3 Uncomfortable periods – cramps, lengthy or heavy bleeding, or sore breasts
4 Peri- or postmenopausal discomfort (hot flashed, weight gain, sweats, insomnia or mental dullness)
3 Skin eruptions with period

If your score is over 6, your hormones may be out of balance and may need a nutritional program that incorporates working with your doctor.

Blood Sugar & Stress _____ **Total Score**

4 Crave a lift from sweets or alcohol, but experience a drop in mood afterwards
4 Family history of diabetes, hypoglycemia or alcoholism
3 Nervous, jittery, irritable, headachy or work, on and off during the day. Calmer after meals.
3 Frequent infections, allergies or asthma, especially when the weather changes
3 Mental confusion, decreased memory, hard to focus or get organized 4
3 Frequent thirst
3 Night sweats (not due to menopause)
5 Light-headed, especially on standing up
4 Crave salty foods or licorice
4 Often feel stressed, overwhelmed and exhausted
4 Dark circles under eyes or eyes sensitive to bright light
4 More awake at night

If your score is over 12, it's important that you work on balancing blood sugar and controlling your stress levels.

Thyroid Function _____**Total Score**

4 Low energy
4 Easily chilled (especially hands and feet)
4 Other family members have thyroid problems
4 Can gain weight without overeating; hard to lose excess weight
3 Have to force yourself to do even moderate exercise
4 Find it hard to get going in the morning
3 High cholesterol
3 Low blood pressure
4 Weight gain began near the start of menses, a pregnancy or menopause
3 Chronic headaches
3 Use food, caffeine, tobacco and/or other stimulants to get going

If your score is over 15, you may need to get your thyroid checked. Your nutritionist can show you ways to support your thyroid, for more energy, naturally.

Food Allergies _____**Total Score**

3 Crave milk, ice cream, yogurt, cheese or doughy foods and eat them frequently
3 Experience bloating after meals
4 Gas, frequent belching
3 Digestive discomfort of any kind
3 Chronic constipation and/or diarrhea
4 Respiratory problems, such as asthma, postnasal drip, congestion
3 Low energy or drowsiness, especially after meals
4 Allergic to milk products or other common foods
3 Under-eat or often prefer beverages to solid foods
3 Avoid food or throw up food because bloating after eating makes you feel fat or tired
4 Can't gain weight
3 Hyperactivity or depression

Severe headaches or migraine

4 Food allergies in the family

If your score is over 12, you may be craving foods you are allergic to. Elimination diets can pinpoint the offending foods, and elimination of them usually results in weight loss and increased energy.

Yeast **_____Total Score**

4 Often bloated; abdominal extension
3 Foggy-headed
2 Depressed
4 Yeast infections
4 Used antibiotics extensively (any point in life)
4 Used cortisone or birth controls for more than one year
4 Have chronic fungus on nails or skin or athlete's foot
3 Recurring sinus or ear infections as an adult or child
3 Achy muscles and joints
4 Rashes
3 Stool unusual in color, shape or consistency

If you scored over 12, you have a yeast problem which your nutritionist can address with dietary changes and natural nutritional therapies.

Brain Chemistry **_____Total Score**

4 Sensitivity to emotion (or physical) pain, cry easily
4 Eat as a reward, for pleasure, comfort or numbness
4 Worry, anxiety, phobia or panic
4 Difficulty getting to sleep or staying asleep
3 Difficulty with focus, attention deficits
2 Low energy, drive and arousal
4 Obsessive thinking or behavior
4 Inability to relax after tension/stress
3 Depression, negativity
4 Low self-esteem, lack of confidence
4 More mood and eating problems in winter or end of day
3 Irritability, anger
4 Use alcohol or drugs to improve mood

If your score is over 10, your brain chemistry and neurotransmitters may be out of balance. A nutritionist can help you improve your brain chemistry naturally.

Low Calorie Dieting **_____ Total Score**

4 Increased cravings for and focus on food, overeating
4 Regain weight after dieting, more than was lost
3 Increased moodiness, irritability, anxiety or depression
3 Less energy and endurance
3 Usually eat less than 2,100 calories/day
3 Skip meals, especially breakfast
3 Eat mostly low-fat carbs like bagels and pasta
2 Constantly think about weight
2 Use aspartame daily
2 Take Prozac or similar serotonin-boosting drugs
2 Have become vegetarian
3 Decreased self-esteem
4 Have become bulimic or anorectic

If your score is over 12, your body may not be burning calories as fast as it could due to low calorie intake. You may also be deficient in critical nutrients. Through counseling, a nutritionist will help educate you on why it's important NOT to deprive yourself of food.