

Nutritional Assessment Questionnaire

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General Information:

Name: _____ Date _____

Address: _____
Street City State Zip Code

Home Phone #: _____ Work/Cell #: _____ Blood Type: _____

E-mail: _____ Date of Birth: _____ Age: _____

Favorite Color: _____ Least Favorite Color: _____

Occupation: _____ Employer: _____

Referred by: _____

Medications currently using

Supplements currently taking

Five Most Significant Health Problems

Intention for consult:

If you have a specific chief complaint, please describe (briefly).

How and when did the problem begin? :

Circle any of the following item you consume:

Alcohol

Candy or other sweets

Chewing tobacco

Cigarettes

Cigars

Coffee

Dairy products

Deep fried foods

Distilled water

Fast food

Fluoridated/chlorinated water

Luncheon meats

Margarine

Non-herbal tea

Refined (white) flour products

Refined sugar

Soft drinks

Instructions: Read the following symptoms and fill in the number that applies:

0 = Do not have the symptom, the symptom does not apply

1 = It is a minor symptom or it rarely occurs

2 = It is a moderate symptom or it occasionally occurs

3 = It is a significant symptom or it frequently occurs

4 = It is a severe symptom or you are aware of it almost constantly

Rate the severity or frequency of the symptom from 0 to 4. How significant is the symptom? How true is the statement—0 means not at all, 4 means extremely true. Where the question is answered by yes or no, circle Y or N.

1. ____ Fingernails chip, peel or break easily

2. ____ Belching or gas within 1 hr. of a meal

3. ____ Distaste for meat (not a vegetarian for moral or other reasons)

4. ____ Fewer than one bowel movement per day

5. ____ Stools hard or difficult to pass

6. ____ Bloating after eating

7. ____ Only specific foods cause bloating

8. ____ Sleepy after eating

9. ____ Sensitive to smoke

10. ____ Feeling “wired” or jittery if drinking coffee

11. ____ Pain between the shoulder blades

12. ____ Bizarre, vivid or nightmarish dreams

13. ____ Metallic taste in the mouth

14. ____ Bitter taste in mouth, especially after meals

15. ____ Become sick after drinking wine (as opposed to other alcoholic beverages)

16. ____ Wake up without remembering dreams

17. ____ Bothered if eating food with monosodium glutamate (MSG)

18. ____ Become intoxicated easily if drinking alcohol

19. ____ Severe hangovers after drinking alcohol

20. ____ Trouble tolerating greasy foods

21. ____ Trouble tolerating aspartame (NutraSweet)

22. ____ Frequent fevers

23. ____ Trouble tolerating garlic or onions

24. ____ Gallbladder attacks (past or present)

25. ____ Urine has a strong odor

26. ____ Dry flaky skin or dandruff

27. ____ Sensitive to chemicals (perfume, insecticides, exhaust fumes)

28. ____ Hemorrhoids or varicose veins

29. ____ Take over the counter pain medication

30. **Y N** Aspirin is an effective pain reliever

31. ____ Sweat a lot

32. ____ Sweat at night

33. ____ Feet have a strong odor or sweat easily

34. ____ Lower bowel gas

35. ____ Alternating constipation/diarrhea

36. ____ Nausea

37. ____ Epigastric (top of stomach) burning or gastric reflux

38. ____ Patches of dry skin, eczema or psoriasis

39. ____ Hair breaks or falls out easily

40. ____ Anus itches

41. ____ Coated tongue

42. ____ Lactose intolerant

43. ____ Colitis, irritable bowel or Crohn's disease

44. ____ Crave sugar

45. ____ Eat a dessert with sugar, donut, soft drink, ice cream etc. (1 = 1x/week; 2 = 2-3x/week; 3 = daily or almost daily; 4 = more than 1x/day)

46. ____ Crave bread or noodles

47. ____ Eat refined white flour products (French, Italian or other white bread, bagels, pasta etc.) [1 = 1x/week; 2 = 2-3x/week; 3 = daily or almost daily; 4 = more than 1x/day]

48. ____ Are there any foods that you feel that you would not want to give up? (Think of foods that you eat every day like bread, cheese etc.)

49. ____ Have you taken tetracyclines (Sumycin, Panmycin, Vibramycin, Minocin) for acne? [1 = 1 mo.; 2 = 2 mo.; 3 = 3 mo.; 4 = 4 mo. or longer]

50. ____ Have you taken broad-spectrum antibiotics for urinary, respiratory or other infection? (1 = 1 course < 2 mo.; 2 = 1 course 2 mo. or longer; 3 = 2x in a single year; 4 = more than 2x in a single year)
51. ____ Hay fever or seasonal allergies
52. ____ Feel worse when in a moldy or musty place
53. ____ Sinusitis (nose stuffy, sinus headaches or sinus infections)
54. ____ Runny or drippy nose
55. ____ Catch colds at the beginning of winter
56. ____ Migraine headaches
57. ____ Binge eating or uncontrolled eating
58. ____ Asthma, wheezing or difficulty breathing
59. ____ Crave coffee or sugar in the afternoon
60. ____ Afternoon headaches
61. ____ Fatigue that is relieved by eating
62. ____ Shaky, headachy, or tired when meals are delayed
63. ____ Family history of diabetes (1 = distant relative; 2 = 1 or 2 direct relatives; 3 = 3 or 4 direct relatives; 4 = more than 4 direct relatives)
64. ____ Frequent thirst
65. ____ Cuts take a long time to heal
66. ____ Frequent urination
67. ____ Frequent infections
68. ____ Numbness or tingling in the extremities
69. ____ Fatigue
70. ____ Cry, become teary or sad for no reason
71. ____ Ankles swell
72. ____ Become cold easily or when others are not
73. ____ Depression
74. ____ If #73 is a symptom of yours, can you characterize your depression as feeling "low" with a strong desire to sleep, sleeping a lot and having trouble getting out of bed
75. ____ If #73 is a symptom, can you characterize your depression as feeling agitated, anxious or having difficulty falling and staying asleep
76. ____ Lack of motivation (function from day to day but lacking initiative)
77. ____ Brittle, coarse hair
78. ____ Difficulty losing weight
79. ____ Frequent colds or the flu
80. ____ Frequent diets (reducing food intake) (1=1 or 2; 2=3 or 4; 3 = 5 or 6; 4 = 7 or more)
81. ____ Crave salt or salty foods
82. ____ Crave greasy or fatty foods
83. ____ Pain on the inside (medial) knee or on one side of the low back
84. ____ Become dizzy when standing up suddenly
85. ____ Trouble getting out of bed in the morning
86. ____ Tend to be a "night" person
87. ____ Tendency to worry
88. ____ Tend to be calm on the outside, troubled inside
89. ____ Changed marital status (1=w/in 2 years; 2= w/in 1 year; 3= w/in 6 mos.; 4 = w/in 3 mos.)
90. ____ Death of a loved one. (1=w/in 2 years; 2= w/in 1 year; 3= w/in 6 mos.; 4 = w/in 3 mos.)
91. ____ Changed jobs, lost a job or started a new job. (1=w/in 2 years; 2= w/in 1 year; 3= w/in 6 mos.; 4 = w/in 3 mos.)
92. ____ How many hours do your work each week? (1= 45 or less; 2= 45-50; 3= 50-55; 4=more than 55)
93. ____ Keyed up, trouble calming down.
94. ____ Fall asleep only to wake up after a few hours and have trouble falling back to sleep
95. ____ Difficulty falling asleep
96. ____ Feelings of insecurity
97. ____ Heart races or palpitates
98. ____ Clench or grind teeth
99. ____ Jaw clicks, pops, locks or makes noise
100. ____ Tension headaches (base of skull)
101. ____ Headaches when hot or out in the sun
102. ____ Get up at night to urinate
103. ____ Decreased ability to taste or smell
104. ____ Get hives
105. ____ Acne
106. ____ Undigested food in stool
107. ____ Taken birth control pills (1= 6 mos. or less ; 2= 1 yr. or less; 3= 1-2 yrs.; 4= more than 2 yrs.)
108. ____ Feel spacey or unreal
109. ____ Rehabilitated or done construction in a house built before 1970 (1= yes, but didn't live there during work; 2= lived there when the work was done; 3= rehabbed more than 1; 4= lived in more than 1 house that's been rehabbed)
110. ____ Fungus or yeast infections
111. ____ Exposure to diesel fumes
112. ____ Do you smoke , how many pack-years (number of years times the number of packs per day)? [1=2 or less; 2=3-5; 3=7-10 and 4= more than 10 pack-years]
113. ____ Did you quit smoking (1= more than 10 yrs ago; 2= 5-10 yrs.; 3=1-5 yrs.; 4= less than 1yr)
114. ____ How many alcoholic beverages each week? (1= 1-7; 2= 8-14; 3= 14-21; 4= more than 21 alcoholic beverages per week)
115. **Y N** Are you a recovering alcoholic?
116. **Y N** History of anorexia or bulimia
117. ____ How many mercury (silver) fillings (1= 1-2; 2= 3-5; 3= 6-7; 4= more than 7 fillings)
118. ____ Have you taken shark cartilage? (mark 1 point for every 3 months on the supplement)

119. **Y N** Diagnosed with chronic fatigue syndrome or fibromyalgia
120. ____ Pain or swelling in the joints
121. ____ Muscles become easily fatigued
122. ____ Anemia that is unresponsive to iron
123. ____ Greasy or shiny stools
124. ____ Clay-colored stools
125. ____ Stomach upset by taking vitamins
126. ____ Hands tremble
127. ____ Calves cramp at night
128. ____ Legs cramp after walking, better after rest
129. ____ Undigested fat in stool
130. ____ (Women) Anxiety, irritability, emotional instability related to menstrual cycle
131. ____ (Women) Depression during period
132. ____ (Women) Weight gain greater than 3 pounds and/or abdominal bloating associated with cycle
133. ____ (Women) Breast tenderness, soreness or swelling associated with cycle
134. ____ (Women) Excess menstrual flow
135. ____ (Women) Sugar, chocolate, or carbohydrate craving associated with cycle
136. ____ Dark circles under the eyes
137. ____ Sense of fullness after meals
138. ____ Do not feel like eating breakfast
139. ____ Feel better if you don't eat
140. ____ Black or tarry stools
141. ____ Pain under right side of ribcage
142. ____ Itchy skin (maybe worse at night)
143. ____ Cold sores, fever blisters or Herpes lesions
144. ____ Sunburn easily or get "sun poisoning"
145. ____ Cough that produces mucus
146. ____ Bruise easily
147. ____ Frequent infections (ear, bladder, lung etc.)
148. ____ Eyes sensitive to bright light
149. ____ Exercise makes you feel worse
150. ____ Blush or face turns red for no reason
151. ____ Pain in chest, left arm or left side of neck
152. ____ Sigh frequently, air hunger or trouble catching breath
153. ____ Fluid retention
154. ____ (Men) Dribble after voiding urine
155. ____ (Men) Frequent urination or urgency to urinate
156. ____ (Men) Interruption of the stream during urination
157. ____ Pain or burning when urinating
158. ____ Bloody, cloudy and/or darkened urine
159. ____ Decreased libido
160. ____ Decreased scalp hair (not pattern baldness)
161. ____ Increased body hair
162. **Y N** Under 4' 10" tall
163. **Y N** Over 6' 6" tall
164. **Y N** Early sexual development
165. ____ Brittle hair that breaks easily
166. ____ Exercise (1= daily; 2= 4x/week or more; 3= 1-3x/week; 4= 1x/week or less)
167. **Y N** (Women) Irregular (non-cancerous) cells found on a PAP smear
168. **Y N** Have you ever had polyps?
169. **Y N** Use of antidepressant medication?
170. **Y N** Have the drugs (in #169) helped?
171. ____ Anxiety
172. **Y N** Use of anti-anxiety medication
173. **Y N** Has anti-anxiety medication helped?
174. ____ Tightness across the shoulder
175. ____ Stiff in the morning
176. ____ Joints are stiff and swollen
177. ____ Bursitis or tendonitis
178. **Y N** Have you ever had a herniated disc
179. ____ Flexible joints or "double jointed"
180. ____ Joints click or pop
181. **Y N** History of stress fractures
182. ____ Bone loss (reduced density on bone scan, loss of height, etc.)
183. **Y N** Are you shorter than you used to be?
184. **Y N** History of kidney stones (or family tendency for kidney stones)
185. **Y N** Yellow in the whites of the eyes
186. ____ (Women) Occasionally skip periods
187. ____ (Women) Excess facial hair
188. ____ (Women) Painful to have sexual intercourse
189. ____ (Women) Bleeding between periods
190. ____ (Women over 35) Irregular menstrual cycle
191. ____ (Women over 35) Hot flashes
192. ____ (Women over 35) Decrease in libido as getting older
193. ____ (Women) Vaginal discharge
194. ____ (Women) Poor concentration associated with certain times of menstrual cycle
195. ____ (Women) Vaginal itching or dryness
196. **Y N** (Women) Are you taking hormone replacement
197. **Y N** (Women) Have you had a partial hysterectomy
198. **Y N** (Women) Have you had a total hysterectomy
199. ____ (Women) Cysts in breasts
200. ____ (Women) Ovarian cysts
201. ____ (Women) Scanty blood flow during period
202. **Y N** Take synthroid or other thyroid hormone

203. **Y N** Are you a vegan (no dairy, meat, or fish)
204. _____ Nutrasweet (aspartame) consumption (1= 1x/wk or less; 2= 2-3x/week; 3= 4-7x/week; 4= more than 1x daily)
205. _____ Sweat has strong odor
206. **Y N** Do you have tinnitus (ringing in your ears)
207. _____ Do you consume margarine? (1= 1x/wk or less; 2= 2-3x/week; 3= 4-7x/week; 4= more than 1x daily)

208. _____ Small bumps on the back of the arm
209. _____ Trouble seeing at night
210. **Y N** Lateral 1/3 of eyebrows doesn't grow hair
211. _____ Eyes itch during hay fever season
212. _____ Rapid heart beat
213. _____ Anxious, nervous or jittery
214. _____ Bad breath

HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit _____ Date began _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis) _____

Outcome _____

What types of therapy have you tried for this problem(s):

☐ diet modification ☐ fasting ☐ vitamin/mineral ☐ herbs ☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ conventional drugs
☐ other _____

List current health problems for which you are being treated: _____

Current medications (prescription or over-the-counter): _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Operation, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right Your weight today _____☐ Unintentional weight loss or gain of 10 pounds or more in the last three months

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner) _____

☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical devices/prosthetics/implants, describe: _____Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations☐ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers) _____Strong like for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ saltyStrong dislike for any one of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ saltyDo you: ☐ Prefer warmth (i.e., food, drinks, weather etc.) ☐ Prefer cold (i.e., food, drinks, weather, etc.) ☐ No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

<input type="checkbox"/> 7 a.m. - 9 a.m.	<input type="checkbox"/> 9 a.m. - 11 a.m.	<input type="checkbox"/> 11 a.m. - 1 p.m.
<input type="checkbox"/> 1 p.m. - 3 p.m.	<input type="checkbox"/> 3 p.m. - 5 p.m.	<input type="checkbox"/> 5 p.m. - 7 p.m.
<input type="checkbox"/> 7 p.m. - 9 p.m.	<input type="checkbox"/> 9 p.m. - 11 p.m.	<input type="checkbox"/> 11 p.m. - 1 a.m.
<input type="checkbox"/> 1 a.m. - 3 a.m.	<input type="checkbox"/> 3 a.m. - 5 a.m.	<input type="checkbox"/> 5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

<input type="checkbox"/> 7 a.m. - 9 a.m.	<input type="checkbox"/> 9 a.m. - 11 a.m.	<input type="checkbox"/> 11 a.m. - 1 p.m.
<input type="checkbox"/> 1 p.m. - 3 p.m.	<input type="checkbox"/> 3 p.m. - 5 p.m.	<input type="checkbox"/> 5 p.m. - 7 p.m.
<input type="checkbox"/> 7 p.m. - 9 p.m.	<input type="checkbox"/> 9 p.m. - 11 p.m.	<input type="checkbox"/> 11 p.m. - 1 a.m.
<input type="checkbox"/> 1 a.m. - 3 a.m.	<input type="checkbox"/> 3 a.m. - 5 a.m.	<input type="checkbox"/> 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERYDAY?

<input type="checkbox"/> Debilitating fatigue	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Constipation	<input type="checkbox"/> Chronic pain/inflammation
<input type="checkbox"/> Depression	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Nausea	<input type="checkbox"/> Fecal incontinence	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Disinterest in sex	<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Discharge
<input type="checkbox"/> Disinterest in eating	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Itching/rash

Medical History

- ☐ Arthritis
- ☐ Allergies/hayfever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins
- Other _____

Medical (Men)

- ☐ BPH
- ☐ Prostate cancer

- ☐ Decreased sex drive
- ☐ Infertility
- ☐ STD
- Other _____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ PMS
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ STD
- Other _____
- Age of first period _____
- Date of last gynecological exam _____
- Mammogram ☐ + ☐ -
- PAP ☐ + ☐ -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- ☐ C-section
- ☐ Surgical menopause
- ☐ Menopause
- Date of last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (parents and siblings)

- ☐ Arthritis, rheumatoid
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide
- Other _____

Health Habits

- ☐ Tobacco:
- Cigarettes: #/day _____
- Cigars: #/day _____
- ☐ Alcohol:
- Wine: #glasses/d or wk _____
- Liquor: #ounces/d or wk _____
- Beer: #glasses/d or wk _____
- ☐ Caffeine:
- Coffee: #6 oz cups/d _____
- Tea: #6 oz cups/d _____
- Soda w/caffeine: #cans/d _____
- Other sources _____
- ☐ Water: #glasses/d _____

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk
- ☐ Run, jog, jump rope
- ☐ Weight lift
- ☐ Swim
- ☐ Box
- ☐ Yoga

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction
- Specific food restrictions:
- ☐ dairy ☐ wheat ☐ eggs
- ☐ soy ☐ corn ☐ all gluten
- Other _____

Food Frequency

- Servings per day:
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- ☐ Skip breakfast
- ☐ Two meals/day
- ☐ One meal/day
- ☐ Graze (small frequent meals)
- ☐ Food rotation
- ☐ Eat constantly whether hungry or not
- ☐ Generally eat on the run
- ☐ Add salt to food

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol, etc.)
- ☐ Herbs - teas
- ☐ Herbs - extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach flowers
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals (e.g., Ensure)
- Other _____

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds and flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

Name _____

Start Date _____

FOOD INTAKE JOURNAL

	MON.	TUES.	WED.	THURS.	FRI.	SAT.	SUN.
BREAKFAST							
LUNCH							
DINNER							
BEVERAGES							
SNACKS							
EXERCISE							
BOWEL MOVEMENTS							

Additional

Notes: _____



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Nutritional Balancing Program Contract and Wavier

SUMMARY OF THE NUTRITIONAL BALANCING PROGRAM:

- Detailed personal health history assessment
- Extensive dietary consultation
- Guided nutrition with appropriate supplementation
- Regimented whole foods dietary suggestions
- Advanced natural health information
- Education on your health that will stay with you

AGENDA:

The integration of natural health protocols will be aimed at deepening your awareness of your own body. Attention will be focused on individualized nutritional regimens and healthy lifestyle changes. You will be educated on your current diet and nutrition and how the two together affect overall health.

FEE:

The fee for the Nutritional Balancing Program is \$270.00. This includes a 1-hour Initial Consultation, 1-hour Profile Report Visit, and 2 ½-hour follow-up visits. This will also include contact via phone or e-mail should you need additional support. All appointments need to be scheduled in advance, and a 24-hour cancellation policy does apply. Broken appointments without 24 hour notice will be charged a \$50.00 cancellation fee. It is your responsibility to stick to your schedule, and the 2 follow up appointments are void 3 months from the date that we review your profile report.

SUPPLEMENTS:

Nutritional supplements may be suggested according to your specific needs. Please note that anything you take should be discussed with your medical doctor if you are currently under their supervision. All supplements once open will not be accepted for a refund.

EXPANDED AND ON-GOING SESSIONS:

In addition to the aforementioned attention given in the Nutritional Balancing Program, Valarie Haag is also available for additional private consultations to discuss other health concerns in more specific detail if time allows. This may include a deeper assessment of chronic health issues beyond the scope of the initial consultation and nutritional counseling already provided. Additional consultation fees will be applied at the rate of \$65 per hour, when scheduled at the same time of the 4-6 week office visit.

VIBRATIONAL HEALING SESSIONS:

To accomplish complete healing of body, mind, and spirit, Vibrational Energy Healing Sessions are available as an adjunct to your Nutritional Balancing Program for an additional fee. A discounted "Package Rate" may apply. These sessions include Reiki Healing, Crystal and Color Balancing, Reflexology, and Aromatherapy. The same 24-hour cancellation policy applies to these sessions.

CLIENT AGREEMENT:

I (client) have read all of the information listed above. I understand that, by signing this document, I agree to the terms of the Nutritional Balancing Program provided by Valarie Haag (Board Certified Traditional Naturopath) as stated above. I understand that she is not my primary care physician, nor is she intending to act as such. I acknowledge that services provided by Valarie Haag are not to be interrupted as diagnosis, treatment, alleviation, or care of any disease of any kind in any way. I hereby authorize Valarie Haag to perform a Nutritional Analysis and develop a customized Nutritional Profile Report with suggestions of dietary, nutritional and lifestyle changes. This information is provided for my education, and how I choose to integrate it into my life is my responsibility. I understand that this is a Nutritional Program aimed at improving my health and that everyone responds differently to the program. Although most individuals respond positively to the program, I am aware that I may respond differently to the nutritional regimen, supplements, etc. provided in the program. I also hereby claim, by signing below, that I currently have no advanced or existing health condition that has not been brought to Valarie Haag's prior attention that would threaten my own health. If such condition(s) do exist, I agree that I must discuss it with her prior to and bring an approved medical report from my doctor that releases me to participate in such a program.

I hereby attest that I am here as a client, this and any subsequent visit, solely on my behalf.

client Printed name of

Date

Signature of client