Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chiropractic Advantage Nutrition Intake Form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **If Yes, How Much per: Day** | **Week** | **Month**  |
| **Do You Smoke?**  |  |  |  |  |  |
| **Drink Alcohol?** |  |  |  |  |  |
| **Drink Coffee?** |  |  |  |  |  |
| **Drink Soft Drinks?** |  |  |  |  |  |
| **Drink Energy Drinks?** |  |  |  |  |  |

**Do you have any food allergies, restrictions, or sensitivities? Yes/No If yes, to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you ever overeat? Yes/No If yes, which foods and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you get weak, light headed, or irritable if you haven’t eaten in a while? Yes/No**

**Please list any food aversions and/or foods you dislike:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How is your skin (without lotion)? Dry Normal Oily Combination Any discolorations? Yes/No**

**How is your hair? Dry Normal Oily Dandruff Excess shedding**

**Are your nails weak or brittle? Yes/No Do your gums bleed? Yes/No**

**Describe your daily energy levels: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best time of day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Worst time of day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How much do you exercise? None Rarely 1-2 times/week 3-4 times/week More than 5 times/wk**

**How is your energy level after exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often do you have a bowel movement? \_\_\_\_\_\_per day/week/month Is it Fluffy? Pebble-Like?**

**How often do you urinate? \_\_\_\_\_\_per day/week/month Do you wake to urinate at night? Yes/No**

**How much stress are you under? None Low Moderate High Very High**

**How do you sleep? Insomnia Wake in the night Trouble falling asleep Sleep well**

**How many hour of sleep per night do you average? \_\_\_\_\_\_\_\_\_\_\_\_\_ Is this enough? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rate your general enjoyment of life: Poor Fair Good Excellent**

**What can we do that would help you the most? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**