The NUTRI-SYSTEMS PROFILE (NSP)

Nutritional Assessment by Body Systems

NSP CLIENT ASSESSMENT FORM

NAME: _____ AGE: _____ DATE: _____

COMPLETE LEFT SIDE OF FORM ONLY: If any of the following symptoms or activities have occurred *within the past three months* (unless otherwise specified), please indicate by checking: **1** for mild or rarely occurring, **2** for moderate or regularly occurring, **3** for severe or often occurring, or **leave blank** if the symptom/statement does not apply.

	Please complete this section		Right Side for Office Use Only	1	2	3	4	5	6	7	8	9	10
1	General fatigue or weakness												
2	Difficulty losing weight												
3	Frequent illness/infections												
4	High stress Lifestyle												
5	Smoking												
6	Drinking more than 2 cups of coffee/day												
7	Bad breath and/or body odour												
8	Constipation												
9	Bags under eyes												
10	Crave sugars, bread, alcohol												
11	Difficulty digesting certain foods												
12	Have used antibiotics in past 10 years												
13	Allergies												
14	Poor concentration or memory												
15	Belching or burping after meals												
16	Skin/complexion problems												
17	Frequent consumption of red meat												
18	Regular use of dairy products												
19	Heavy alcohol consumption												
20	Exposure to toxins/chemicals												
21	Frequent mood swings												
22	Depressed and/or irritable												
23	Brittle fingernails												
24	Dry, brittle hair, split ends												
25	High fat/high cholesterol diet												
26	Nervousness/anxiety/tension/worry												
27	Insomnia/restless sleep												
28	Low fibre diet												
29	Muscle cramps												
30	Sleepy when sitting up												
31	Female: menstrual cramps												
32	Bronchitis/asthma/pneumonia/emphysema												
33	Cellulite												
34	Cold hands and feet												
35	Varicose veins												
36	Feeling out of control												
37	Food/chemical sensitivities												
38	Frequent yeast/fungus problems												
39	Bones break easily, osteoporosis												
40	Too little exercise												
	SCORES SUBTOTAL												

NAME: _____ DATE: _____ ASSESSMENT# _____

(**Check:** 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or often occurring, or **leave blank** if the symptom/statement does not apply.)

Please complete this section			Right Side for Office Use Only	1	2	3	4	5	6	7	8	9	10
	SUBTOTALS												
41	Excessive mucous												
42	Short of breath climbing stairs												
43	Tingling in lips, fingers, arms, legs												
44	Chest pains												
45	Very rapid or slow heart beat												
46	Painful, hard or thin bowel movements												
47	Alternating constipation/diarrhea												
48	Recurrent bladder infections												
49	Female: Menopause, hot flashes												
50	Female: PMS												
51	Difficult urination												
52	Swollen glands, puffy throat												
53	Lower abdominal pain												
54	Frequent need to urinate												
55	Joint pain												
56	Sinus inflammation/discharge												
57	Arthritis												
58	Sudden weight gain/loss												
59	Headaches/Migraines												
60	Female: Taking birth control pills												
61	Lower back pains												
62	Dry, flaky skin												
63	Drink less than 6 glasses of fluids/day												
64	Water retention												
65	Low sex drive												
66	Feeling heavy/bloated after meals												
67	Chronic cough												
SCORES TOTAL													

SYSTEMS RATING TABLE: For Office Use Only

1.	Digestive	
2.	Intestinal	
3.	Circulatory/Cardiovascular	
4.	Nervous	
5.	Immune/Lymphatic	
6.	Respiratory	
7.	Urinary	
8.	Glandular/Endocrine	
9.	Structural	
10.	Reproductive	

COMMENTS:

1. THE DIGESTIVE SYSTEM

NOW PLEASE COMPLETE THE FOLLOWING SUBQUESTIONNAIRES USING THE SAME RATING SYSTEM:

1 - for mild or rarely occurring
2 - for moderate or regularly occurring
3 - for severe or often occurring
*or leave **blank** - if the symptom / statement does not apply*

UNDERACTIVE STOMACH

Excessive gas, belching or burping after meals	
Stomach bloated after eating	
Sleepy after eating	
Longitudinal striations on fingernails	
Eat when rushed/in a hurry	
Halitosis	
Full feeling after heavy meat meal	
Heavy, tired feeling after eating	
Nausea after taking supplements	
Acne	
Undigested food in the stool	

OVERACTIVE STOMACH

Stomach pain 1 hour after eating or at night	
Burning sensation in stomach	
Pain aggravated by worry / tension	
Hiatal hernia	
Gastritis, gastric ulcer	
Nausea, vomiting	
Sensation of acidity in abdominal area	
Heartburn, indigestion	
Blood in stool	
Lower back pain	
Long term aspirin use	

LIVER

Yellow or pale fingernails	
Skin oily on nose and forehead	
Fats/greasy foods cause nausea, headaches	
Vertical white streaks on fingernails	
Onions, cabbage, radishes, cucumbers cause bloating /gas	
Bad breath; bad taste in mouth	
Excess body odour	
High cholesterol / high cholesterol diet	
Migraine headaches	
Discomfort underneath right ribcage	
Food allergies	
Irritable, easily angered	
Weight gain around the abdomen	
Yellow palms	
Jaundice	
Poor concentration	
Difficulty losing weight	
Acne, boils, rashes, psoriasis or eczema	
Constipation	

PANCREAS

Severe abdominal pain	
Nausea and vomiting	
Slow digestion; feel full for hours after eating	
Fever	
Alcohol addiction	
Jaundice	

GALL BLADDER

Gall stones; history of gall stones	
Stool appears clay-coloured, foul odoured	
Constipation	
High cholesterol diet; High blood cholesterol levels	
Severe pain in right upper abdomen	

DYSGLYCEMIA

Hungry up to 3 hours after eating	
Strong, sudden cravings for sweets, starches coffee or alcohol	
Nervous/anxious feelings relieved by eating	
Irritable if late for, or skip, a meal	
Overweight	
Addicted to coffee with sugar and/or colas	
Frequent "midnight snacks"	
Family history of diabetes	
Fatigue	
Frequent headaches	
Fainting spells	
Depression	
Lose temper easily	

2. THE INTESTINAL SYSTEM

NOW PLEASE COMPLETE THE FOLLOWING SUBQUESTIONNAIRES USING THE SAME RATING SYSTEM:

1 - for mild or rarely occurring
2 - for moderate or regularly occurring
3 - for severe or often occurring
*or leave **blank** - if the symptom / statement does not apply.*

CANDIDIASIS

Extreme fatigue	
Recurrent vaginal infections	
Frequent use of antibiotics	
White coated tongue, oral thrush	
Crave sugars, bread, alcohol	
Headaches	
Tonsillitis, recurrent strep throat	
Itchy, watery or dry eyes	
Skin flushes	
Chronic indigestion, frequently use antacids	
Always cold, especially in extremities	
F: PMS	
Pain in pelvic area	
Abdominal gas and bloating	
Loss of sex drive	
Cystitis, repeated bladder infection	
Increasing food and chemical sensitivities; severe reaction to tobacco, perfume, etc	
F: endometriosis / ovary problems	
Chronic diarrhea	
Hives, psoriasis, acne, skin rashes	
Rectal itching	
Abnormal muscle aches from exercise	
Excessive wax in ears	
Unexpected / unexplained weight gain	
Impotence	
Canker sores	
Athlete's foot, finger / toenail fungus, ringworm	
Jock itch	
"Brain fog"	
Irritability	
Memory loss	

CANDIDIASIS (cont.)

Mental confusion	
Depression or anger for no reason	
Anxiety / panic attacks	
Inability to concentrate	
Phobic / compulsive	
Lethargy	
Mood swings	
Itchy ears, nose, anus	

PARASITES

Forgetfulness	
Slow reflexes	
Gas and bloating	
Unclear thinking	
Loss of appetite	
Yellowish or pale face	
Fast heartbeat	
Heart pain	
Pain in navel	
Eating more than normal but still feeling hungry	
Blurry or unclear vision	
Pain in the back, thighs, shoulders	
Numb hands	
Drooling while sleeping	
Damp lips at night	
Dry lips during the day	
Grind teeth while asleep	
Bedwetting	
Lethargy; chronic fatigue	
Dark circles under eyes	
Cancer	

5. THE LYMPHATIC / IMMUNE SYSTEM

NOW PLEASE COMPLETE THE FOLLOWING SUBQUESTIONNAIRES USING THE SAME RATING SYSTEM:

1 - for mild or rarely occurring
2 - for moderate or regularly occurring
3 - for severe or often occurring
*or leave **blank** - if the symptom / statement does not apply*

THYMUS (IMMUNITY)

Excessive sleep	
Very susceptible to infections	
Swollen glands: tonsils, throat, armpits	
History of cancer, MS, Parkinson's arthritis	
Loss of appetite	
Headaches	
Soreness on both sides of neck at shoulder	
Feel puffiness in throat	
Look older than chronological age	
Flu-like symptoms often occur	
Lupus	

ALLERGIES

Acne, psoriasis, dermatitis, eczema	
Rapid pulse, heart irregularities	
Frequent headaches	
Hay fever	
Frequent cravings for certain foods	
Periods of blurred vision	
Repeated ear trouble	
Hyperactivity	
Dizzy spells	
Periods of confusion	
Poor concentration	
Epilepsy	
Muscle cramps or spasms	
Abnormal body odour	
Excessive sweating, night sweats	
Bowel disease: IBS, IBD, Crohn's, etc.	
Joint pains or stiffness	
Frequent night urination	
Wheezing	
Pale face	
Hives	
Nose runs constantly	
Noticeable changes in writing throughout day	
Nosebleeds	
Bloating or gas after eating certain foods	
Canker sores	
Dark circles under eyes	
Stuffy nose	

8. THE GLANDULAR / ENDOCRINE SYSTEM

NOW PLEASE COMPLETE THE FOLLOWING SUBQUESTIONNAIRES USING THE SAME RATING SYSTEM:

1 - for mild or rarely occurring *2 - for moderate or regularly occurring*

3 - for severe or often occurring *or leave **blank** - if the symptom / statement does not apply*

UNDERACTIVE THYROID / HYPOTHYROID

Distinct, lethargic tiredness or sluggishness	
Cold hands or feet	
Mercury amalgams (fillings)	
Gain weight easily, fail to lose on diets	
Constipation, less than one bowel movement a day	
Low energy in the morning	
Low pulse rate	
Low body temperature, especially at bed rest	
Hair dry, brittle, dull, lifeless	
Flaky, dry rough skin	
Feel stiff after sitting still for some time	
Mood swings	
Unusually square and wide fingernails	
High cholesterol	
Diminished sex drive	

PITUITARY

Headaches affecting one side of head	
F: loss of menstrual function	
Moody	
Overweight from waist down	
Overweight from waist up	
Excessive urination	
Pain in little finger of left hand	
Swelling in ankles, fingers and/or feet	
Cold hands or feet	
Pain in left side of upper neck	

OVERACTIVE THYROID / HYPERTHYROID

Losing weight without trying	
Heart races while at rest	
Feel warm / flushed at room temperature	
Hands shake or tremble	
Protruding tongue	
Heart palpitations	
Nervous behaviour, hyperactivity	
Insomnia	
Increased appetite	
Frequent bowel movements, diarrhea	
Excessive sweating without exercising	

ADRENALS

Stress or emotional upsets cause exhaustion	
Blood pressure decreases when going from a lying position to a standing position	
Perspire excessively	
Neck and/or shoulder tension	
Frequent headaches	
Bow lines (depressed furrows) on fingernails	
Occasional cold sweats	
Tightness or lump in throat, especially when emotionally disturbed	
High or low blood pressure	
Rapid pulse	
Short temper	
Puffy face	

9. THE STRUCTURAL-MUSCULAR / SKELETAL SYSTEM

NOW PLEASE COMPLETE THE FOLLOWING SUBQUESTIONNAIRES USING THE SAME RATING SYSTEM:

1 - for mild or rarely occurring *2 - for moderate or regularly occurring*

3 - for severe or often occurring *or leave **blank** - if the symptom / statement does not apply*

SKELETAL

Pain, swelling, stiffness in joints	
Joint inflammation (rheumatoid arthritis)	
Pain, stiffness, inflammation of spine	
Facial pain	
Joints make popping sounds	
Gout	
Ankylosing spondylitis	
Bones fracture easily	
Gradual loss of height	
Tooth loss; teeth "falling out"	
Lack of exercise	
Rounding of shoulders; stooping	
F: Menopause	
Pain in forearm or biceps	
Cramps in calf muscle during sleep or exercise	
Painful cramping of feet or toes	
Teeth prone to decay, frequent toothaches	
Malformation of bones	
Insomnia	
Muscles weak, weak grip, light objects feel heavy	
Heart palpitations	
Diet high in animal foods (meat, dairy, eggs)	

MUSCULAR

Muscle pain	
Muscle weakness	
Sprains; muscle strains	
Muscle(s) spasm	

NEUROMUSCULAR

Muscles wasting in some part of the body	
Numbness or loss of sensation	
Mood swings and/or depression	
Blurred or double vision	
Tingling and/or numbness, especially in extremities	
Muscular stiffness	
Difficulty breathing	
M: impotence	
Tremors	
Loss of peripheral vision	
Slurred speech	
Objects fall from hands, reach in wrong place	
Hands tremble	
Impaired speech	

LIFESTYLE ASSESSMENT FORM

Name: _____

Date: _____ Age: _____ Sex: F / M Height: _____ Weight: _____

Please answer each of the following questions. If you require additional space, use the back of the page.

What is your purpose in coming here today? _____

_____

_____

What are your main health concerns/complaints? Please list in priority:

_____

_____

Have you experienced any major trauma in the past 5 years? _____

_____

What level of stress do you feel you are experiencing at this time? Please quantify on a scale of 1 (low) to 10 (high): 1 2 3 4 5 6 7 8 9 10

What are the major causes or factors of your stress? (rate all that apply on a scale of 1 (low) to 10 (high):

___financial ___career ___personal ___marriage ___health

___family ___spiritual ___unfulfilled expectations

___other (please elaborate) _____

How does your stress manifest itself? _____

_____

Do you use any coping mechanisms? _____

What do you do for exercise? (indicate type, frequency, time of day and duration) _____

_____

On a scale of 1 (low) to 10 (high), how would you describe your energy levels? _____

Do you experience any lulls or highs in your energy levels throughout the day? If so, at what time of day? _____

How many hours on average do you sleep daily? (include naps) _____

What time do you go to sleep? _____ Awaken? _____

Do you have trouble falling asleep? ☐ Staying asleep? ☐

Do you awaken feeling rested? Yes ☐ No ☐ Do you snore? Yes ☐ No ☐

What is your occupation? _____

Do you enjoy your work? Yes ☐ No ☐ Sometimes ☐

How many hours each day do you work? _____

At what times do you start and end work? _____

Do you work shifts or are you on a regular schedule? _____

For Office use only:

LIFESTYLE ASSESSMENT FORM

Name: _____

Do you smoke? Yes ☐ No ☐ If yes, how much and for how long?

_____

If no, does anyone in your household or workplace smoke? Yes ☐ No ☐

Do you wish to gain weight? ☐ lose weight? ☐ how much? _____

By when do you wish to reach your goal weight? _____

What is your main motivation to change your weight? _____

_____

How many hours do you spend daily, on average: driving _____
watching television _____ reading _____ in front of computer _____

What are your interests and hobbies? _____

_____

Do you vacation regularly? Yes ☐ No ☐

When was your last vacation? _____

Do you actively participate in any spiritual discipline (church, religious group, meditation, etc.)? Yes ☐ No ☐

MEDICAL HISTORY:

Are you currently taking any medication? Yes ☐ No ☐
List all medications and the reason(s) for each _____

_____

_____

Do you take: birth control pills ☐

Have you taken antibiotics over the past five years? Yes ☐ No ☐

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts/dosages: _____

_____

_____

Do you have any allergies or sensitivities? Yes ☐ No ☐

If so, please list: _____

_____

Do you have anaphylaxis (life-threatening allergy)? If so, please describe:

_____

Do you have any silver-mercury fillings? Yes ☐ No ☐

Have you ever been:

a) Diagnosed with an illness? Yes ☐ No ☐ If so, please explain

_____

b) Hospitalized? Yes ☐ No ☐ If yes, for what reason?

_____

Have you had surgery to remove your gall bladder? ☐ tonsils? ☐ appendix? ☐

For Office use only:

Name: _____

For Office use only:

How often do you have a bowel movement? _____
Do you strain to have a bowel movement? Yes ☐ No ☐ Occasionally ☐
Related to particular food or circumstances? _____

_____

Do you have loose bowel movements? Yes ☐ No ☐ Occasionally ☐
Related to particular food or circumstances? _____

_____

Is there undigested food in your stools? Yes ☐ No ☐ Occasionally ☐

Do you use recreational drugs? Yes ☐ No ☐
If yes, how often and what type? _____

Have you ever been treated for drug and/or alcohol dependency? Yes ☐ No ☐
If yes, please circle which you have been treated for.

FAMILY HISTORY:

Hereditary Diseases: Use "F" for father, "M" for mother, "S" sibling, "G" for grandparent, "O" for other(s):

	Allergies		Diabetes		Intestinal Disease
	Alcoholism		Drug Abuse		Kidney Dysfunction
	Arthritis		Gall Bladder Issues		Mental Illness
	Asthma		Heart Disease		Osteoporosis
	Autoimmune Disease		Hypertension		Skin conditions
	Cancer - type:				Ulcers

Other diseases (please list) _____

Have you experienced fungal infections (e.g. jock itch, athlete's foot)?
Yes ☐ No ☐ If yes, please describe: _____

Have you experienced a decline in sexual interest? Yes ☐ No ☐
If yes, please describe:

_____

Have you had kidney or gall stones? Yes ☐ No ☐
If yes, please describe:

_____

FEMALES:

Are you or could you be pregnant? Yes ☐ No ☐
Have you noticed any changes in menses, for example the frequency, duration, flow, clotting, or other changes? Yes ☐ No ☐
If so, please specify _____

Do you suffer from PMS symptoms? Please specify _____
Are you pre-menopausal? Yes ☐ No ☐ Post-menopausal? Yes ☐ No ☐
Are you experiencing any menopausal symptoms? Yes ☐ No ☐
If yes, please specify _____

LIFESTYLE ASSESSMENT FORM

Name: _____

For Office use only:

Have you had a bone density test? Yes ☐ No ☐
If yes, what was the result? _____

MALES:

Have you experienced any prostate problems (e.g. frequent urination, discomfort during urination)? Yes ☐ No ☐ If yes, please describe:

_____

DIETARY HABITS:

How many times a day do you eat:

Main Meals _____ Times of day: _____

Snacks _____ Times of day: _____

Do you eat meals: with family ☐ home alone ☐ on the run ☐
restaurant ☐ fast food ☐

Do you feel there are restrictions to your diet due to preferences of others such as family, roommates, etc? Yes ☐ No ☐ If yes, please explain:

_____

How many ½ cup servings of each do you typically eat in a day:

_____ Fruit: Fresh ☐ Dried ☐ Canned ☐
_____ Vegetables: Cooked ☐ Raw ☐
_____ Whole Grains
_____ Protein: Types _____
_____ Dairy Products: Type _____
_____ Other: Specify _____

Provide examples of your typical meals:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

Do you eat or use (indicate "1" for "rarely", "2" for "regularly","3" for "often")

	Aluminum pans		Margarine		Candy
	Microwave		Fried foods		Fast foods
	Luncheon meats		Cigarettes		
	Artificial sweeteners (Nutra Sweet, aspartame, Splenda)				
	Refined foods (pastries, white bread/pasta/rice, etc.)				

LIFESTYLE ASSESSMENT FORM

Name: _____

Please indicate how many cups of the following you drink per day:

	Tap water		Fresh vegetable juices
	Bottled or spring water		Prepared vegetable juices
	Coffee		Soft drinks *(diet)*
	Tea		Soft drinks *(regular)*
	Herbal tea		Red wine
	Fresh fruit juices		White wine
	Fruit juices *(prepared)*		Beer
	Milk *(1%, 2% or whole)*		Other alcoholic beverages
	Milk *(skim)*		Other _____

For Office use only:

Are you a: ☐ meat eater? ☐ vegetarian? ☐ vegan?
How often do you eat meat? ☐ daily ☐ 3-5/week ☐ once/week or less
How often do you consume dairy products?
☐ daily ☐ 3-5/week ☐ once/week or less

What are your favourite foods? _____

_____

How often do you eat them? _____

Which food(s) do you crave, and how often do you eat them? _____

_____

Do you avoid certain foods? Yes ☐ No ☐ If so, why?

_____

Do you experience any symptoms if meals are missed? Explain:

_____

Do you experience any symptoms after meals? Explain:

_____

Comments: _____

_____

CLIENT STATEMENT:

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Date: _____ Signature: _____

Name: (please print) _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (C) _____

Thank you for your cooperation.
All information contained on this form will be kept strictly confidential.

PEDIATRIC FORM

To be used for children 12 years of age or under, and in conjunction with all other forms.

Child's Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: F _____ M _____

SYMPTOMS: (mark C for current and P for past symptoms)

_____ Abdominal pain	_____ Excessive fatigue	_____ Nightmares
_____ Acid reflux	_____ Excessive perspiration	_____ Night sweats
_____ Anemia	_____ Flat feet	_____ No appetite
_____ Bad breath	_____ Frequent headaches	_____ Nosebleeds
_____ Bed wetting	_____ Gas	_____ Painful urination
_____ Bleeding gums	_____ Hearing loss	_____ Parasites
_____ Blood in urine	_____ Heart murmur	_____ Psoriasis
_____ Body odour	_____ High fevers	_____ Rash
_____ Bruises easily	_____ Hives	_____ Sensitive to light
_____ Canker sores	_____ Hyperactivity	_____ Sleep problems
_____ Changes in appetite	_____ Itchy anus	_____ Stomach aches
_____ Congestion	_____ Itchy nose (or picks nose)	_____ Sore throat
_____ Constipation	_____ Itchy vagina	_____ Teeth grinding
_____ Cough	_____ Jaundice	_____ Talks in sleep
_____ Cries easily	_____ Joint pains	_____ Walks in sleep
_____ Diarrhea	_____ Migraines	_____ Weight gain
_____ Dizzy spells	_____ Motion sickness	_____ Weight loss
_____ Dry Skin	_____ Nervousness	_____ Wheezing
_____ Eczema		_____ Vomiting spells

For Office Use Only:

MEDICAL HISTORY: (check all that apply)

☐ ADD/ADHD	☐ Dental problems	☐ Neural Tube Defect
☐ Allergies (environmental)	☐ Developmental problems	☐ Pneumonia
☐ Allergies (food)	☐ Ear infections	☐ Rubella
☐ Asthma	☐ Frequent colds	☐ Rheumatic Fever
☐ Autism	☐ Impaired speech	☐ Scarlet Fever
☐ Bronchitis	☐ Measles	☐ Tonsillitis
☐ Chicken Pox	☐ Meningitis	☐ Whooping cough
☐ Croup	☐ Mumps	☐ Other (specify):

Nutritional Supplements (please list). Include herbal and homeopathic as well.

For Office Use Only:

MEDICATIONS. (check all that apply, and indicate the length of time the child received each medication.)

☐ Antacids	☐ Declectin	☐ Methylphenidate (Ritalin)
☐ Antibiotics	☐ Decongestant	☐ Oral Steroids
☐ Antidepressants	☐ Dextroamphetamine Dexedrine, Dextrostat, Adderall	☐ Pemoline (Cylert)
☐ Anti-Histamine	☐ Epilepsy medication	☐ Tylenol
☐ Aspirin	☐ Ibuprofen	☐ Others (please list)
☐ Clonidine	☐ Inhaled Steroids	

Are you aware of any allergies to medications?

IMMUNIZATIONS: (check all that apply)

☐ Diptheria	☐ Influenza	☐ IPV (Polio)
☐ DPT	☐ Measles	☐ PNEU (Pneumoccocal disease)
☐ Hemophilus	☐ MENI (Menigococcal disease)	☐ Small pox
☐ Hepatitis	☐ MMR (Measles, Mumps, Rubella)	☐ Tetanus
☐ Hib (Hemophilus Influenza)	☐ Mumps	☐ VAR (Varicella or chicken pox)

Were there any reactions to immunization(s)? If so, at what age?

MOTHER'S HEALTH DURING PREGNANCY: (check all that apply)

☐ Alcohol, Cigarettes, Drug Consumption	☐ Gestational Diabetes	☐ Stress
☐ Anemia	☐ Hypertension	☐ Thyroid problems
☐ Bleeding	☐ Nausea	☐ Uterine infection
☐ Dental problems	☐ Physical or Emotional Trauma	☐ Other (specify):
☐ Diabetes	☐ Pre-eclampsia	

For Office Use Only:

MEDICATIONS WHILE PREGNANT:

MEDICATIONS WHILE NURSING (Mother):

TERM:

Full _____ Premature _____ Late _____

Weight at birth _____ lb

LABOR & DELIVERY:

Was pregnancy induced? _____

Vaginal _____ C-Section _____ Complications during labor? _____

Medications during or after labor? _____

FEEDING:

Breast fed _____ Bottle fed _____

When was formula started? _____

When were solid foods first introduced? _____

What were the first foods introduced? _____

_____

Did your baby have any of the following problems?

_____ Jaundice
_____ "Blue Baby"
_____ Colic
_____ Diarrhea
_____ Thrush