NANCY GUBERTI
M.S., C.N.C.

CERTIFIED HOLISTIC NUTRITIONIST

Nancy Guberti, MS, CN, Functional Medicine Nutritionist
203-542-7390 nancy@nancyguberti.com
nancyguberti.com
Healthy Living Everyday, Your Wellness Blueprint: http://bit.ly/HealthyLivingEveryday
Total Wellness Membership http://totalwellnessempowerment.com/membership/
Instagram: https://www.instagram.com/nancyguberti/
YouTube: https://www.youtube.com/nancyguberti
Podcast: http://nancyguberti.com/podcast/

Today's Date:_____ Referred by:_____ Email Address:_____

Name:_____ ○M ○F Birthdate: / / Age:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____ Occupation:_____

Height:_____ Current Weight:_____ Desired Weight:_____ Marital Status: S M D W

No. of children:_____ Blood Type:____ Daytime phone: ( )_____ Evening phone: ( )_____

1. **COMPLAINTS** – Please rank your current complaints and rate their severity (on a scale of 1 to 10, 10 being the most severe):

2. **OTHER INFORMATION** – Please tell us any additional information or concerns about your health:

3. **MEDICATIONS** – Please list any medications you are currently taking and how long you have taken them (including birth control pills, aspirin, pain medications, etc):

List of vitamins/supplements/herbs:

4. **SMOKING** – Do you currently smoke? ◯Yes ◯No If yes, how much? How long have you smoked?

5. **SURGERIES** – What surgeries, operations, traumas, car accidents, etc. have you had?

6. **STRESS** – Please rate your current stress level (on a scale of 1 to 10, 10 being the highest stress):

What is the main reason(s) for your stress?

What step(s) are you taking to reduce your stress level?

7. **DENTAL WORK** – Indicate how many of the following you have:

Silver fillings___	Gold crowns or inlays___	Root canals___	Braces___	Composites (tooth-colored)___
Bleeding Gums___	Porcelain crowns___	Sensitive teeth___	Bridgework___	Implants___
Bad Bite___	Partial or full dentures___	Veneers___	Temporaries___	New cavities___

8. **SLEEP** – How is your sleep? *Check those that apply.*

◯Restful ◯Restless ◯Hard to get to sleep ◯Wake up often ◯Get up during the night ◯Bad dreams

Other complaints?

What time do you usually go to sleep?___ Number of hours of sleep per night?___

9. **DIGESTION** – How is your digestion? *Check those that apply.*

◯Adequate ◯Poor ◯Acid reflux ◯Burp often ◯Bloating ◯Burning/pain in stomach

Other complaints?

10. **URINATION** – How are your daily urinations? *Check those that apply.*

◯Every 2 to 3 hours ◯Too frequent ◯Sense of urgency ◯Too small amount ◯Too large amount

◯Is burning ◯Up at night several times

Other Complaints?

11. **BOWELS** – How are your bowel eliminations? *Check those that apply.*

How often? ◯3 times daily ◯Once per day ◯Skip days

Amount: ◯Normal ◯Too little ◯Too large

Consistency: ◯Normal ◯Too hard ◯Very soft ◯Diarrhea

BOWELS Cont'd. How are your bowel eliminations? *Check those that apply.*
◯Color: ◯Brown ◯Black ◯Yellowish ◯Green
Other: ◯Lots of mucus ◯Lots of gas ◯Foul smell
Other Complaints?

12. **WOMEN ONLY** *Check those that apply.* Are you pregnant? ◯Yes ◯No ◯Breast-feeding? ◯Have monthly periods?
Date of last period?_____ Going through menopause? ◯Yes ◯No
Periods stopped? ◯Yes ◯No Hysterectomy? ◯Yes ◯No Monthly periods regular (28 day cycles)? ◯Yes ◯No
Number of days of your menstrual flow?____

Check any of symptoms you experience associated with your period: ◯Cramping ◯Bloating ◯Feeling weak
◯Mood swings ◯Cravings ◯Heavy bleeding ◯Back pain ◯Headaches ◯Bright red blood ◯Dark clotty blood
Other menstrual complaints?

13. **EXERCISE** – What kind of exercise do you do?

How often?_____ For how long at a time?_____

14. **SUNLIGHT** – Amount of sunlight you receive daily?____ Hours spent daily under fluorescent lights?____

15. **EYEWEAR** – Do you wear contact lenses? ◯Yes ◯No Glasses? ◯Yes ◯No If so, how many hours per day?____

16. **ELECTROMAGNETIC – Exposure** How many hours do you spend daily: Watching TV? ____
Working on a computer?____ Talking on a phone?____ Talking on a cellular phone?____ Wearing a headset?____
Wearing a wrist-watch (with battery)?____ Near electrical equipment for long periods of time (such as copy machines, high power lines,computers, etc.)?____ When you sleep, is your head within 10 feet of a plug-in clock?____

17. **CLOTHING** – How often do you wear 100% natural clothing (cotton, ramie, wool, silk, or linen)?_____
Synthetic clothing (polyester, acrylic, nylon, rayon, etc.)?_____ Blends (natural fabric combined with synthetic)?_____

18. **PERSONAL CARE PRODUCTS** – List the brand names that you use: *Please take time to complete this list.*
Shampoo?

Shave Cream?

Deodorant?

Dish Washing Liquid/Powder?

Toothpaste?

Laundry Soap?

Soap?

Tub/Tile Cleaner?

Hand/Body Lotion?

Glass Cleaner?

Facial Cleanser/Moisturizer?

All Purpose Cleaner?

Hair Spray/Gel?

Perfume/Cologne?

Hair Dye?

Hair Permanent?

Fingernail/Toenail Polish?

Face make-up/ Eye make-up?

Other chemical exposure (from yard, workplace, art chemicals, etc.)?

19. **APPLIANCES** – *Check which of the following you use*

◯Gas stove ◯Electric stove ◯Electric heater ◯Electric blanket ◯Water bed ◯VitaMix ◯Microwave ◯Oven
◯Air Purifier (Brand: _____) Water Purifier (Brand: _____)

20. Cookware What type of cookware do you use? ◯Stainless steel ◯Aluminum ◯Iron ◯Teflon-coated ◯Glass
Other types:

21. **SHOWER FILTER** – What brand of shower filter do you use (for chlorine protection)? _____
When was your filter last changed?

22. **PETS** – Do you have a pet(s)? ◯Yes ◯No

23. If so, what kind/how many? ____ Are they allowed in the house? ◯Yes ◯No On your bed? ◯Yes ◯No

What do you feed your pet(s)?

FOOD CHOICES – What percentage of food is home cooked: ____ Where do you get the rest from? _____
Check each type of food you eat often.

1. Pre-made foods: ◯Canned food ◯Boxed cereals ◯Frozen dinners ◯Bottled or frozen juices ◯Take-out food
2. Red meat (beef, pork, lamb): ◯Commercially grown ◯Naturally raised (Brand: _____)
3. Chicken: ◯Commercially grown ◯Naturally raised (Brand: _____)
4. Turkey: ◯Commercially grown ◯Naturally raised (Brand: _____)
5. Fish: ◯Canned tuna ◯Fresh fish ◯Frozen fish ◯At restaurants
6. Fresh vegetables: ◯Commercially grown ◯Organically grown ◯Farmer's market
7. Fresh fruit: ◯Commercially grown ◯Organically grown ◯Farmer's market
8. Whole grains: ◯Commercially grown ◯Organic
9. Whole beans: ◯Commercially grown ◯Organic
10. Eggs/ Butter: ◯Commercial eggs ◯Naturally grown eggs ◯Commercial butter ◯Natural butter ◯Margarine
11. Milk: ◯Commercial milk ◯Nut milk ◯Rice milk ◯Hemp seed ◯Coconut milk ◯Goat's milk ◯Soy milk
12. Cheese: ◯Commercial cheese ◯Organic cheese
13. Condiments: ◯Salt & pepper ◯Sea salt ◯Ketchup ◯Mustard ◯Vinegar ◯Olive Oil ◯Mayonnaise
14. Coffee (including decaf) ◯Black tea ◯Caffeine drinks Other beverages _____
15. ◯Fried foods
16. ◯Bread ◯Bagels ◯Buns ◯Muffins Other _____
17. ◯Fast food
18. ◯Yogurt ◯Ice cream ◯Cottage cheese ◯Sour cream
19. ◯Crackers
20. ◯Soft drinks (colas, etc.)

21. ◯Artificial sweeteners (NutraSweet, Equal, Sweet 'N Low, Splenda) ◯Stevia or Xylitol ◯Agave Nectar
22. ◯Alcohol (wine, beer, etc.)
23. ◯Potato or corn chips
24. ◯Roasted nuts ◯Peanut butter
25. ◯Pasta
26. ◯Chocolate Candy, pastries, sweets Cookies

QUICK SYMPTOM QUESTIONNAIRE — *Circle or underline any symptom that applies to you*

Is depleted brain chemistry the problem?

◯Sensitivity to emotional (or physical) pain
◯Eat as a reward or for pleasure, comfort, or numbness
◯Difficulty getting to sleep or staying asleep
◯Obsessive thinking or behavior
◯Depression, negativity
◯More mood and eating problems in winter or at the end of the day
◯Cry easily
◯When worry, anxiety, phobia, or in a panic
◯Low energy, drive, and arousal
◯Inability to relax after tension, stress
◯Low self-esteem, lack of confidence
◯Irritability, anger
◯Use alcohol or drugs to improve mood

Are you suffering because of low-calorie dieting?

◯Increased cravings for and focus on food; overeating
◯Increased moodiness, irritability, anxiety, or depression
◯Usually eat less than 2,100 calories a day
◯Eat mostly low-fat carbohydrates (bagels, pasta, frozen yogurt, and others)
◯Take Prozac or similar serotonin-boosting drugs
◯Have become bulimic or anorectic
◯Regain weight after dieting, more than was lost
◯Less energy and endurance
◯Skip meals, especially breakfast
◯Constantly think about weight
◯Use aspartame (NutraSweet) daily
◯Have become vegetarian
◯Increased self-esteem

Are you struggling with blood sugar instability or high stress?

◯Crave a lift from sweets or alcohol, then experience a drop in energy and mood after ingesting them
◯Family history of diabetes, hypoglycemia, or alcoholism
◯Nervous, jittery, irritable, headachy, weak, or teary on & off throughout the day; may be calmer after meals
◯Frequent infections, allergies, or asthma, especially when weather changes
◯Mental confusion, decreased memory, hard to focus or get organized
◯Frequent thirst ◯ Night sweats (not menopausal)
◯Light-headed, especially on standing up

ADRENALS —

◯Crave salty foods or licorice
◯Dark circles under eyes or eyes sensitive to bright light
◯Often feel stressed, overwhelmed, and exhausted
◯More awake at night

Do you have unrecognized low thyroid function?

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

Are you addicted to foods you are actually allergic to?

◯Food Allergies in family ◯Allergic to milk products or other common foods
◯Crave milk, ice cream, yogurt, cheese, or doughy foods (pasta, bread, cookies, among others) and eat them frequently
◯Experience bloating after meals
◯Gas, frequent belching
◯Digestive discomfort of any kind
◯Chronic constipation and/or diarrhea
◯Respiratory problems, such as asthma, postnasal drip, congestion
◯Low energy or drowsiness, especially after meals
◯Under eat or often prefer beverages to solid food
◯Avoid food or throw up food because bloating after eating makes you feel fat or tired
◯Can't gain weight
◯Hyperactivity or manic-depression
◯Severe headaches, migraines

Are your hormones unbalanced? *Woman Only*

◯Premenstrual mood swings
◯Irregular periods or migraines
◯Experienced a miscarriage, or infertility
◯Peri- or postmenopausal discomfort (e.g., hot flashes, weight gains, sweats, insomnia, or mental dullness)
◯Premenstrual or menopausal food cravings
◯Use(d) birth control pills or other hormone medication
◯Uncomfortable periods – cramps, lengthy or heavy bleeding, or sore breasts
◯Skin eruptions with period

Note: Some men experience "male menopause" as a result of hormonal imbalance.

Do you have yeast overgrowth triggered by antibiotics, cortisone, or birth control pills?

◯Often bloated ◯Abdominal distention ◯Foggy-headed ◯Depressed
◯Have chronic fungus on nails or skin or athlete's foot
◯Recurring sinus or ear infections as an adult or child
◯Achy muscles and joints ◯Rashes ◯Stool unusual in color, shape or consistency

Do you have fatty acid deficiency?

◯Crave chips, cheese, and other rich foods more than, or in addition to, sweets and starches
◯Have ancestry that includes Irish, Scottish, Welsh, Scandinavian, or coastal Native American
◯Alcoholism and depression in the family history
◯High cholesterol ◯Low HDL levels ◯Feel heavy, uncomfortable, and "clogged up" after eating fatty foods
◯History of hepatitis or other liver or gallbladder problems
◯Light-colored stool ◯Hard or foul-smelling stool ◯Pain on right side under your rib cage

Family Health History

Health history of your father: _____

Health history of your mother: _____

Health history of siblings: _____

Your current health concerns: _____

Past health concerns: _____

FOOD HABITS-Typical Diet

Please fill out your typical diet for the last few weeks. Please be as detailed as possible. (For example, instead of writing "chicken," identify what brand and how it was made such as "baked Murray's chicken." Instead of writing "salad," identify what it's made of, such as "salad made w/organic baby green lettuce, commercial cherry tomatoes & Olive Oil.")

BREAKFAST: (Time eaten: ____)

LUNCH (Time eaten: ____)

DINNER (Time eaten: ____)

SNACKS (Time eaten: ____)