Welcome to Nutritional Concepts

Please bring to your 90 minute appointment:

- Names of Medications (dosages) and Dietary Supplements ***If phone consult - pictures would be beneficial****
- Completed questionnaire
- Three day lifestyle and food diary
- Bloodwork (no more than eight months old) **with** blood type
- Optional: Prescription from your physician with diagnosis code(s). See details below.
- Optional: If 2 hour appointment, we need your 23andme OR Ancestry raw data prior to your appointment.

Payment is expected upon receipt of service. We do not bill to insurance. *However, we recommend bringing a prescription (on an Rx) from your physician with diagnosis code(s) and the words "Medical Nutrition Therapy". We put the diagnosis on a Superbill for you to submit. Medicare may cover for diabetes, renal disease, obesity, and well visits with a doctor's Rx. We cannot guarantee that our services will be covered, however.*

Bloodwork Requirements:

***Most clients go through their physicians for convenience with submitting to insurance.**
**We do not accept labs taken before or after a surgical procedure if you had an infection, or for life insurance.*

CBC (including basophils and eosinophils)
CHEM SCREEN with HDL/LDL cholesterol differential
CO2 (as bicarbonate)
Thyroid
ESR (Sed Rate)
Ferritin
CRP (C-Reactive Protein)
Simple Urinalysis
Blood Type (if you do not know)
Vitamin D 25 Hydroxy 25(OH) D

Please fast from 10PM the evening prior to the test. Water is the only beverage allowed. Stop dietary supplements 48 hours prior to the blood draw. If taking antihistamines, antibiotics or oral cortisone, please wait 48 hours, 2 weeks and 4 weeks respectively, unless medically necessary.

If not through your physician, you have two other options for bloodwork:

1. **Quest Diagnostics (doctor's RX not needed)**: go to questdirect.questdiagnostics.com to order labs
2. **Our lab affiliation is Northern Illinois Clinical Labs (NICL) in Northbrook.**
   *Cost: $223.00 or $243.00 (if you need blood type)
   *****We do not bill to insurance. However, we will give you a receipt with diagnosis to submit to insurance.

Come to our office at Professional Plaza, 1535 Lake Cook Road, Suite 204 in Northbrook to pick up a requisition and pay for lab services (the lab requires 3 business days to process bloodwork). Our office hours are M-SAT 9AM-5PM. NICL lab office hours are M-F 8:00AM-3:30PM. No appointment needed. NICL has other lab locations.

Directions to our office: GPS doesn't always provide accurate directions here. Call 847-498-3422 for directions.

Cancellation Policy: Please honor our 24 hour notice policy. If you are unable to keep your scheduled appointment, please give us time to fill your spot. Unless there is an illness or emergency, we will charge you half the appointment fee.

*If coming for an in-person visit, many of our patients are chemically sensitive, so please refrain from wearing scented products.

Lifestyle & Food Diary
(typical patterns)

	FOODS	DRINKS	PHYSICAL ACTIVITY *Type and # of Minutes*
Breakfast			
Lunch			
Dinner			
Snacks			

Client Information Section:

First & Last Name _____ **Appt. Date** ___/____/_____
Sex___ **Weight** ____ **Height** ____ **Age**____ **Birth Date** __/__/____ **Frame Size- S**__ **M**__ **L**__

Address _____

City/State/Zip Code_____

Preferred Phone number _____ **Other Phone number** _____

e-mail address_____

Blood Type_____ **Physician Name**_____

How Did You Hear About Us?_____

Notes (FOR HEALTH PROFESSIONAL USE ONLY):

Medical & Health Evaluation

Please complete the questionnaire to the best of your ability.
The more information we have, the better we can serve you.

Part A: Lifestyle Risks*

Instructions: Circle the number that best describes usage
0= Never
1= Have had in the past, but not recently
2= occasionally (1 x weekly or less)
3= regularly (2-4 x weekly)
4= daily (5-7 x weekly)
**Leave blank any items that you choose not to answer.*

Section 1: Medication/Drug Consumption

1.	Antacids specify _____	0	1	2	3	4
2.	Antibiotics/Antifungals	0	1	2	3	4
3.	Antidepressants	0	1	2	3	4
4.	Anti-diabetic oral medication	0	1	2	3	4
5.	Insulin (injectable)	0	1	2	3	4

6.	Aspirin	0	1	2	3	4
7.	Antihistamines	0	1	2	3	4
8.	Non-aspirin (ie: Tylenol)	0	1	2	3	4
9.	Chemotherapy	0	1	2	3	4
10.	Radiation	0	1	2	3	4
11.	Cortisone	0	1	2	3	4
12.	Non steroidal anti-inflamm.	0	1	2	3	4
13.	Heart medication	0	1	2	3	4
14.	High blood pressure meds	0	1	2	3	4
15.	Hormones specify _____	0	1	2	3	4
16.	Oral contraceptives	0	1	2	3	4
17.	Laxatives	0	1	2	3	4
18.	Muscle Relaxant	0	1	2	3	4
19.	Sleeping pills	0	1	2	3	4
20.	Diuretics	0	1	2	3	4
21.	Thyroid medication	0	1	2	3	4
22.	Ulcer medication specify _____	0	1	2	3	4
23.	Recreational Drugs	0	1	2	3	4
24.	Other specify _____	0	1	2	3	4

Section 2: Food/Drink Habits

Instructions: Circle the number that best describes usage

0= Never

1= Have had in the past, but not recently

2= occasionally (1 x weekly or less)

3= regularly (2-4 x weekly)

4= daily (5-7 x weekly)

**Leave blank any items that you choose not to answer.*

1.	Alcohol (wine/beer) specify # of drinks _____	0	1	2	3	4
2.	Alcohol (hard liquor) specify # of drinks _____	0	1	2	3	4
3.	Coffee specify # of cups _____ decaf ____ regular ____	0	1	2	3	4
4.	Milk specify # of 8oz. glasses _____ skim ____ lowfat ____ regular ____	0	1	2	3	4
5.	Vegetables specify # of servings _____	0	1	2	3	4
6.	Fruit specify # of servings _____	0	1	2	3	4

7.	Fruit juice	0	1	2	3	4
	specify # of servings _____					
8.	Red meat	0	1	2	3	4
	specify # of 2oz. servings _____					
9.	Fish	0	1	2	3	4
	specify # of 3oz. servings _____					
	specify types of fish _____					
10.	Bread (including bagels, rolls)	0	1	2	3	4
	specify # of servings _____					
11.	Poultry	0	1	2	3	4
	specify # of 2oz. servings _____					
12.	Soft Drinks	0	1	2	3	4
	specify # of 12oz. glasses _____	Regular _____	Diet ____			
13.	Tea	0	1	2	3	4
	specify # of 8oz. cups _____	decaf ____	regular ___			
14.	Water	0	1	2	3	4
	specify # of 8oz. glasses ____	mineral (bottled-sparkling) ____	mineral (bottled- still) ____			
		tap (unfiltered) ____	tap (filtered) ____			
15.	Hard Candy	0	1	2	3	4
16.	High sugar foods	0	1	2	3	4
	(cakes, cookies, pies, added sugar, etc.)					
17.	Non caloric sweeteners	0	1	2	3	4
	Aspartame (Nutrasweet)____	Sucralose (Splenda)____	Stevia____	Monk Fruit____		
	Saccharin (Sweet & Low)____	Other (please specify)_____				
18.	Luncheon meats	0	1	2	3	4
	(i.e.bologna, salami, smoked meats, hot dogs)					
19.	Salty foods or added salt to prepared foods w/o tasting first	0	1	2	3	4
20.	Fried foods	0	1	2	3	4
21.	"Fast Foods"	0	1	2	3	4
	(Wendy's, McDonald's, Burger King, etc.)					
22.	Dieting to lose weight	0	1	2	3	4
23.	Eat Breakfast	0	1	2	3	4
24.	Eat Quickly	0	1	2	3	4
25.	Food Chemicals (preservatives, artificial colors/flavors, MSG)	0	1	2	3	4

Section 3: Lifestyle Habits/Environmental Exposure

26.	Chewing Tobacco	0	1	2	3	4
27.	Cigarettes	0	1	2	3	4
28.	Cigars	0	1	2	3	4
29.	Exposure to 2nd hand smoke	0	1	2	3	4
30.	Exercise	0	1	2	3	4
	(0=none; 1=1 day weekly; 2=2 days weekly; 3=3 days weekly; 4=4 days weekly)					
31.	If you exercise 5-7x weekly	0	1	2	3	4
	(0=15 min or less; 1=20-30min; 2=35-60min; 3=65-90min; 4=90+min)					
32.	Exposure to excess stress	0	1	2	3	4
	(0=15 min or less; 1=20-30min; 2=35-60min; 3=65-90min; 4=90+min)					
33.	Sleep duration	___ less than 7 hrs/day	___ more than 9 hrs/day			
34.	Home Water Filtration	Bath __ yes __ no				
		Drink __ yes __ no				
35.	Cosmetics use	Natural __	Regular ___			
36.	Bath & Body product use	Natural __	Regular ___			
37.	Household product use	Natural __	Regular ___			
38.	Insecticide use	Natural __	Regular ___			
39.	Lawn Care Chemical use	Natural __	Regular ___			
40.	Dry Cleaned Clothing	Natural __	Regular ___			
41.	Is your home mold-free?	__ yes	__ no	__ not sure		

42. Live 100ft. or < from power lines? __ yes __ no __ not sure
43. Do you grill more than 1x weekly? __ yes __ no
44. Do you use air fresheners? __ yes __ no
45. Television use ___ 2 hrs/day ___ 2-4 hrs/day ___ more than 4 hrs/day
46. Cell phone use ___ minutes/day OR ___ hours/day
47. Computer use ___ minutes/day OR ___ hours/day
48. Give a description of your vocation/career and, if applicable, how it is harming your health and/or contributing to your symptoms: _____

_____

Section 4: Nutritional Supplements - PLEASE bring all supplement bottles to your appointment; if by phone, PLEASE provide pictures or manufacturer & product name)

Part B-Family Health History Questionnaire*

Instructions: Circle or highlight the number that applies.
0= Does not apply
1= Myself
2= Mother
3= Father
4= Grandparents
**Leave blank any items that you choose not to answer.*

1.	Do you have a history of headaches?	0	1	2	3	4
2.	Do you have a history of cancer?	0	1	2	3	4
3.	Do you have a history of diabetes?	0	1	2	3	4
4.	Do you have a history of heart disease?	0	1	2	3	4
5.	Do you have a history of arthritis?	0	1	2	3	4
6.	Do you have a history of hepatitis?	0	1	2	3	4
7.	Do you have a history of depression?	0	1	2	3	4
8.	Do you have a history of alcoholism?	0	1	2	3	4
9.	Do you have a history of HIV/AIDS?	0	1	2	3	4
10.	Do you have a history of drug abuse?	0	1	2	3	4
11.	Do you have a history of smoking addiction?	0	1	2	3	4
12.	Do you have a history of osteoporosis?	0	1	2	3	4
13.	Do you have a history of dementia or alzheimer's disease	0	1	2	3	4
14.	Do you have a history of dreaming or daydreaming about food?	0	1	2	3	4
15.	Do you have a history of eating when you are very happy or very sad?	0	1	2	3	4

Part C-Health Related Symptoms*

Instructions: Circle or highlight the number that most accurately describes your symptoms.
0= I don't have the symptom.
1= The symptom is mild or occurs rarely.
2= The symptom is moderate or occasional.
3= The symptom is severe or often.

1.	Watery or itchy eyes	0	1	2	3
2.	Swollen, red, or sticky eyeballs	0	1	2	3
3.	Excessive Eye debris	0	1	2	3
4.	Itchy ears	0	1	2	3
5.	Fluid in ears	0	1	2	3
6.	Frequent ear infections	0	1	2	3
7.	Ringing in ears	0	1	2	3
8.	Hearing loss	0	1	2	3
9.	Need to clear throat	0	1	2	3
10.	Mucus in throat	0	1	2	3
11.	Hoarseness	0	1	2	3
12.	Irritated or sore throat	0	1	2	3
13.	Swollen gums or lips	0	1	2	3
14.	Canker sores	0	1	2	3
15.	Coughing	0	1	2	3
16.	Stuffy nose	0	1	2	3
17.	Sinus problems	0	1	2	3
18.	Hay fever	0	1	2	3
19.	Sneezing attacks	0	1	2	3
20.	Hives or rashes	0	1	2	3
21.	Nausea	0	1	2	3
22.	Water retention	0	1	2	3
23.	Specific food cravings	0	1	2	3
24.	Pain or aches in joints	0	1	2	3
25.	Pain or aches in muscles	0	1	2	3
26.	Arthritis	0	1	2	3
27.	Stiffness	0	1	2	3
28.	Limitation in range of motion	0	1	2	3
29.	Muscle fatigue	0	1	2	3
30.	Whole body fatigue	0	1	2	3
31.	Heartburn	0	1	2	3
32.	Rapid or pounding heart	0	1	2	3
33.	Irregular or skipped heartbeat	0	1	2	3
34.	Asthma	0	1	2	3
35.	Bronchitis	0	1	2	3
36.	Shortness of breath	0	1	2	3
37.	Breathing difficulty	0	1	2	3
38.	Frequent or urgent urination	0	1	2	3
39.	Hyperactivity	0	1	2	3
40.	Attention deficit disorder	0	1	2	3

41.	Anxiety	0	1	2	3
42.	Nervousness	0	1	2	3
43.	Irritability	0	1	2	3
44.	Mood swings	0	1	2	3
45.	Headaches	0	1	2	3
46.	Faintness	0	1	2	3
47.	Insomnia	0	1	2	3
48.	Dizziness	0	1	2	3
49.	Vertigo	0	1	2	3
50.	Erratic vision (not corrected by glasses or contact lenses)	0	1	2	3
51.	Anger or aggressiveness	0	1	2	3
52.	Chest pain	0	1	2	3
53.	Binge or compulsive eating	0	1	2	3
54.	Excessive overweight	0	1	2	3
55.	Extremely underweight	0	1	2	3
56.	Apathy, lethargy	0	1	2	3
57.	Poor memory	0	1	2	3
58.	Poor concentration	0	1	2	3
59.	Poor coordination 0	1	2	3	
60.	Difficulty in making decisions	0	1	2	3
61.	Slurred speech	0	1	2	3
62.	Stuttering or stammering	0	1	2	3
63.	Depression for no apparent reason	0	1	2	3
64.	Flushes or hot flashes	0	1	2	3
65.	Acne	0	1	2	3
66.	Hair loss	0	1	2	3
67.	Excessive sweating	0	1	2	3
68.	Frequent colds or flu	0	1	2	3
69.	Surgery of any kind in last 6 months	0	1	2	3
	If so, what kind? _____				
70.	Enlarged prostate	0	1	2	3
71.	Alcohol binges or being drunk	0	1	2	3
72.	Dark circles or bags under eyes	0	1	2	3
73.	Yellow or Grey skin	0	1	2	3
74.	Genital itch or discharge	0	1	2	3
75.	Food poisoning (includes salmonella shigella, giardia, e coli)	0	1	2	3
76.	Diarrhea	0	1	2	3
77.	Constipation	0	1	2	3

78.	Belching	0	1	2	3
79.	Gas or bloating	0	1	2	3
80.	Abdominal or Intestinal discomfort from 1- 4 hours after eating	0	1	2	3
81.	Iron deficiency anemia	0	1	2	3
82.	Very pale skin with dark circles or or sunken eyes	0	1	2	3
83.	Digestive disorders	0	1	2	3
84.	Craving for unusual foods or non-food items	0	1	2	3
85.	Fatigue, apathy, or lethargy with poor concentration or comprehension	0	1	2	3