Welcome to Nutritional Concepts _____!

Your Appointment is _____ @ _____

Please bring to your 90 minute appointment with Bonnie:

- ☐ Medications and Dietary Supplements
- ☐ Completed questionnaire
- ☐ Three day lifestyle diary
- ☐ Bloodwork (less than six to eight months old) with blood type
- ☐ Optional: Prescription from your physician with diagnosis code(s). See details below.
- ☐ Optional: 2 hour appointment: Email raw genetic data from 23 and me OR Ancestry 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). We put the diagnosis on a Superbill for you to submit. Medicare also covers medical nutrition therapy for diabetes, renal disease, obesity, and well visits with a doctor's Rx. While we cannot guarantee that our services will be covered, this protocol gives you the best chance.*

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 okay. Do not take dietary supplements 24 hours prior. If taking antihistamines, antibiotics or oral cortisone, please call our office.

If not through your physician, 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 does not always provide accurate directions to our office. If you need clarification, call 847-498-3422.

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.*

**Many of our patients are chemically sensitive, so please refrain from wearing scented products.*

CLIENT INFORMATION SHEET

WELCOME TO OUR HEALTH OFFICES. NONE OF OUR SERVICES, NUTRITIONAL COUNSELING, CHIROPRACTIC AND MASSAGE THERAPY, SHOULD BE SUBSTITUTED FOR APPROPRIATE MEDICAL CONSULTATION OR TREATMENT.

OUR GOAL IS TO HAVE AVAILABLE TO YOU THE BEST, MOST QUALIFIED AND PROFESSIONAL HEALTH CARE SERVICES. WE INTEND TO REFER WHEN NECESSARY, TO EDUCATE THE COMMUNITY, AND TO EDUCATE AND WORK WITH THE ENTIRE FAMILY SO THAT EVERYONE MAY HAVE A HEALTHIER LIFESTYLE.

NAME _____ DATE_____ AGE_____
LAST FIRST

LEGAL GUARDIAN'S NAME (If you are under 18) _____

BIRTHDATE _____ OCCUPATION _____

ADDRESS _____ CITY _____ STATE _____

ZIP CODE _____ E-MAIL _____

HOME PHONE _____ WORK PHONE _____ CELL_____

PHYSICIAN _____

HOW DID YOU HEAR ABOUT US? _____

LIST CURRENT HEALTH CONCERNS/SYMPTOMS:

LIST ALL SURGERIES:

LIST ALL CURRENT MEDICATIONS INCLUDING ASPIRIN:

WE EXPECT PAYMENT UPON RECEIPT OF SERVICES. PLEASE HONOR OUR 24 HOUR CANCELLATION POLICY.

NUTRITIONAL HISTORY & RECOMMENDATIONS

Client Name _____ Date (appt.) _____

Address _____ Phone _____

Current Nutritional and Health Problems _____

_____

PLEASE DO NOT WRITE BELOW* *PLEASE DO NOT WRITE BELOW* *PLEASE DO NOT WRITE BELOW

STATUS

Height _____ Weight _____ Edema: Yes ____ No ____ Pallor _____ Blood Type_____

Complexion _____ Muscle Tone _____

SUSPECTED NUTRITIONAL IMBALANCES

Vitamins _____ Minerals _____

Acid/Alkaline Balance _____

Food Allergies/Sensitivities _____

Other Allergies/Sensitivities _____

Digestion: Good____ O.K.____ Needs Improvement_____ Esophagus _____

Stomach _____ Intestines _____ Colon _____

DIETARY CONSIDERATIONS

Calories: Too many ___ Not enough ___ Recommendation for Daily Caloric Intake _____

Fiber: Good ___ Needs more ___ How much daily? _____

Fruit servings: Good ___ Not enough ___ # of servings ___ Sources _____

Vegetable servings: Good ___ Needs more ___ # of servings ___ Sources_____

Protein servings: Good ___ Not enough ___ Too much ___ # of servings _____

Sources _____

Calcium: _____ mg. needed daily Sources - Dairy _____Non-dairy _____

Fat: Good _____ Too much _____ Not enough _____ Recommendations - _____ gm. daily _____# servings daily

% of total diet _____ Sources _____

Sodium: Good _____ Too much _____ Not enough _____ Recommendations - _____ mg. daily

Non-caloric Sweeteners: _____Equal _____Saccharin _____ Splenda _____ Stevia _____ # servings daily

Sweeteners: Good _____ Too much _____ not enough _____ Sources _____

Total Carbohydrates: Good _____ Too much _____ Not enough _____ Sources _____

Bread/Grain Carbohydrates: Good _____ Too much _____ Not enough _____ Sources_____

Food Plan ___ Follow-up _____ Recommendation for Other Services_____

Three Day Lifestyle Diary
(or typical patterns)

DAY ONE

Foods

Drinks

Physical Activity

Hours Slept

DAY TWO

Foods

Drinks

Physical Activity

Hours Slept

DAY THREE

Foods

Drinks

Physical Activity

Hours Slept

NCI Wellness Evaluation

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

Information Section:

First & Last Name _____ Date ___/____/_____

Sex___ Weight ____ Height ____ Age____ BLOOD TYPE ____ Frame Size- S__ M__ L__

e-mail address_____

Address _____

City/State/Zip Code_____

Phone number _____

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	0	1	2	3	4
	specify _____					
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	0	1	2	3	4
	specify _____					

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	0	1	2	3	4
	specify _____					
23.	Recreational Drugs	0	1	2	3	4
24.	Other	0	1	2	3	4
	specify _____					

Section 2: Food/Drink Habits

1.	Alcohol (wine/beer)	0	1	2	3	4
	specify # of drinks _____					
2.	Alcohol (hard liquor)	0	1	2	3	4
	specify # of drinks _____					
3.	Coffee	0	1	2	3	4
	specify # of cups _____					
	decaf ____ regular ____					
4.	Milk	0	1	2	3	4
	specify # of 8oz. glasses _____					
	skim ____ lowfat ____ regular ____					
5.	Vegetables	0	1	2	3	4
	specify # of servings _____					
6.	Fruit	0	1	2	3	4
	specify # of servings _____					
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 ____ distilled ____ mineral (bottled) ____					
	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)____					
	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" (Wendy's, McDonald's, Burger King, etc.)	0	1	2	3	4
22.	Chocolate	0	1	2	3	4
23.	Margarine/Butter Substitute __ with transfat __ no transfat	0	1	2	3	4
24.	Butter	0	1	2	3	4

25. If you could eat as much as you want of any food, what would it be?
(specify) _____

Section 3: Lifestyle Habits/Environmental Exposure

25.	Chewing Tobacco	0	1	2	3	4
26.	Cigarettes	0	1	2	3	4
27.	Cigars	0	1	2	3	4
28.	Exposure to 2nd hand smoke	0	1	2	3	4
29.	Food Chemicals (preservatives, artificial colors/flavors, MSG)	0	1	2	3	4
30.	Dieting to lose weight	0	1	2	3	4
31.	Eat Breakfast	0	1	2	3	4
32.	Eat Quickly	0	1	2	3	4
33.	Exercise	0	1	2	3	4
34.	If you exercise 5-7x weekly (0=15 min or less; 1=20-30min; 2=35-60min; 3=65-90min; 4=90+min)	0	1	2	3	4
35.	Exposure to excess stress	0	1	2	3	4

36. Sleep duration ___ less than 7 hrs/day ___ more than 9 hrs/day

37. Home Water Filtration Bath __ yes __ no
Drink __ yes __ no

38.	Cosmetics use	Natural __	Regular ___
39.	Bath & Body product use	Natural __	Regular ___
40.	Household product use	Natural __	Regular ___
41.	Insecticide use	Natural __	Regular ___
42.	Lawn Care Chemical use	Natural __	Regular ___
43.	Dry Cleaned Clothing	Natural __	Regular ___

44. Is your home mold-free? __ yes __ no __ not sure
45. Live 100ft. or < from power lines? __ yes __ no __ not sure
46. Do you grill more than 1x weekly? __ yes __ no
47. Do you use air fresheners? __ yes __ no
48. Television use ___ 2 hrs/day ___ 2-4 hrs/day ___ more than 4 hrs/day
49. Cell phone use ___ minutes/day OR ___ hours/day
50. Computer use ___ minutes/day OR ___ hours/day
51. 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 supplement bottles to appt.)

Instructions- Check all items you consume on a daily basis

1.	Vitamin A	____5000-10,000 i.u.	____10,000 i.u. or greater	
2.	Beta Carotene	____10,000 i.u. or greater		
3.	Vitamin C	____500mg or less	____1000mg	____1500mg or greater
4.	Vitamin E	____100-400i.u.	____1000i.u. or greater	
5.	Vit. B-3 (Niacinamide)	____50 mg. or greater		
6.	Vitamin B-6	____50 mg. or greater		

7.	Vitamin B-12	____50 mcg. or greater	
8.	Folic Acid	____400 mcg. or greater	
9.	Vitamin D	____400i.u.	____800i.u. or greater
10.	Calcium	____500mg. or less	____1500mg. or greater
11.	Magnesium	____250-400mg.	____1000mg. or greater
12.	Zinc	____15mg. or less	____60mg. or greater
13.	Chromium	____100mcg. or less	____450mcg. or greater
14.	Iron	____15-18mg.	____19mg. or greater
15.	Selenium	____100mcg. or less	____500mcg. or greater
16.	CoEnzyme Q10	____30mg. or less	____100mg. or greater
17.	Lactobacillus Acidophilus and/or Bifidus		_____ specify
18.	Digestive Enzymes		_____ specify
19.	Omega-3 (EPA/DHA)	____Less than 1000 mg.	____More than 1000 mg.
20.	Other:	_____ specify	

Part B-Family Health History Questionnaire*

Instructions: Circle 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?	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 the number that most accurately describes your symptoms.
0= I don't have symptom.
1= The symptom is mild or occurs rarely.
2= The symptom is moderate or occasional.
3= The symptom is severe or often.
**Leave blank any items that you choose not to answer.*

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
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