Sarah S. Luikart, L.Ac., ACN
License # TX AC00885

Nutrition & Food Therapy Health Intake

Important: The information in this form will help your practitioner (Sarah Senter Luikart, L.Ac) give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing or underlying role in the diagnosis and treatment of your problem.
All of the information provided is strictly confidential

Name: ____ **Date:** _______________________

DOB:___________________________ **Age:** ________ **Gender Identification:** _____________

Home Address: ____

Phone #: _______________________________ **Email:** ____________________________________

Occupation(s): ____

Marital Status: Single / Engaged / Married / Divorced / Widowed (please circle one)

Do you have children? YES / NO

If so, how many? ________________ **Age(s):** ____

How many people are in your household total? ______________________________________

Do you have any pets? What kind? ____

Please state the reason(s) for your upcoming visit:

____

____

____

____

How severe are your symptoms at their worst?

1 Very Mild/Occasional 2 Mild 3 Moderate 4 Pretty Bad 5 Severe 6 Debilitating

What lifestyle changes or treatments have you tried to help your condition?

____

____

____

Eating Habits:

How many days per week do you eat:

Breakfast: _______ Lunch: _______ Dinner:________

Do you snack? ____ Yes ____ No
If so, when?

____

Do you buy or pack your lunches?

____ Buy # days per week:____ ____ Pack # days per week:____

Do you eat out? ____ Yes ____ No
How many meals per week?____

What type of restaurants do you usually choose?
1. _____________________ 4. _____________________ 7. _____________________
2. _____________________ 5. _____________________ 8. _____________________
3. _____________________ 6. _____________________ 9. _____________________

Who usually prepares the food at home?

____

Who does the grocery shopping?

____

Do you enjoy cooking? ____ Yes ____ No

Please specify how many of the following you drink *per day (in cups/glasses)* :

______ alcohol ______ caffeinated coffee ______ decaf coffee
______ frozen smoothies ______ diet soft drinks/sodas ______ fruit juice
______ green tea ______ herbal tea ______ regular soft drinks / sodas
______ black tea ______ sports drinks ______ water _______ sparkling water

Please indicate any beverages that are not listed that you consume regularly:

____

Health History:

Do you have what you would consider good energy levels through the day?

____

Do you often feel tired or sluggish after eating meals?

____

Do you find you need to eat often (every 2-3 hours) to avoid getting tired or irritable?

____

Do you find you gain weight easily, or need to exercise rigorously to lose weight?

____

Does anyone in your immediate or extended family have Diabetes? If so, please list.

____

Do you consider yourself: ____ Overweight ____ Underweight ____ I'm happy with my weight.

Is one of your health goals to lose weight? YES / NO

Do you have any of the following:

___ Constipation ___ Loose stools/diarrhea ___ Irregular Bowel Movements
___ Bloating ___ Gas ___ Indigestion ___ Acid Reflux/GERD ___ Acne
___ Headaches ___ IBS ___ Anxiety ___ Depression ___ Allergies
___ Fatigue ___ Joint Pain ___ Autoimmune disease ___ Thyroid disease
___ Anemia ___ Low appetite ___ Celiac disease ___ 'Leaky gut'/ IP

Have you ever had an eating disorder? YES / NO

If so, did you receive treatment for this disorder or have you gained tools to manage this disorder? Please explain as much as possible:

____
____
____
____
____

Do you have any known food allergies or sensitivities? ____ Yes ____ No
If so, which foods/food allergens do you avoid and why?

1. ____
2. ____
3. ____
4. ____
5. ____

What nutritional supplements or herbs are you currently taking and why?

Supplement / Herb	Reason	Dosage/Duration of Use

How many hours do you sleep at night? ______________________________
Do you feel rested with this amount? YES / NO

Do you struggle with:

_____ not falling asleep easily
_____ waking up in the night
_____ excessive, vivid dreaming
_____ insomnia

Do you exercise or practice movement regularly? YES / NO / OFF & ON

What type of movement or exercise do you like to do? ______________________

Do you practice any meditation or mindfulness techniques to reduce/manage stress?
____
____

Goals/Expectations:

Do you want to change your eating habits? ____ Yes ____ No
Why? ____

Do you have any expectations from your visit today? ____ Yes ____ No
What are they?____

____

Please describe a typical day of meals & routine in your life. Fill out the chart below as best you can, including a few examples, if needed:

Morning Routine: What time upon waking?
Breakfast Foods:
Snack between breakfast and lunch?
Lunch Foods:
Snack between lunch and dinner?
Dinner Foods:
Bedtime Routine: What time to bed?

Thank you! Please email this completed form to info@sarahsenterlac.com prior to your appointment.