blum MD CENTER FOR HEALTH

Blum Center For Health
34 Rye Ridge Plaza
Rye Brook, NY 10573
914-652-7800

Patient Intake Form

Welcome to Blum Center for Health! This is the first step on your path to wellness and we look forward to meeting with you in person.

We have created this comprehensive intake form for you to fill out in advance of coming to see us. We realize it might take some time for you to go through, but this will give you an opportunity to think and remember about your past medical history, about your current medical concerns and reasons for seeking our help. Having all this information on paper will be very helpful when you come in, and we will review this together during your medical or nutrition consultation. We have learned that it is often hard for our patients to remember everything when sitting in front of us!

See you soon,

Susan S. Blum, MD, MPH
Medical Director

Elizabeth Greig, MSN, FNP
Nurse Practitioner, Functional Medicine

Mary Gocke, RD
Nutritionist, Functional Medicine

* We ask that you please refrain from wearing perfume, cologne, or scented body lotions at the time of your visit since we have many patients with severe allergies. Thank you in advance for your consideration.

SECTION 1: PATIENT INFORMATION

Name			Date
Age	Date Of Birth	Social Security #	Gender
Occupation			

Primary Address			Alternate Address		
Street			Street		
City	State	Zip	City	State	Zip
Home Phone			Work Phone		
Cell Phone			Fax		
Email Address			Permission to leave a message on your answering machine? ☐ Yes ☐ No		
Emergency Contact			Emergency Phone:		

Referred by: ☐ Book ☐ Website ☐ Media ☐ Friend or Family

☐ Other _____

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INSURANCE INFORMATION

Member Name	☐ Self ☐ Spouse ☐ Parent

Name of Insurer	State	Plan #

SECTION 2: MEDICAL HISTORY

What brings you to Blum Center For Health? _____

_____

_____

If you had 3 wishes for our visit today, what would they be?

_____

_____

_____

When did you last feel well? _____

_____

_____

_____

_____

_____

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SYMPTOM REVIEW

Please check if you have had these symptoms in the past and/or in the recent 6 months (including now)

SKIN PROBLEMS:

NOW PAST

- ☐ ☐ Acne
- ☐ ☐ Athlete's foot
- ☐ ☐ Bumps back of upper arms
- ☐ ☐ Cellulite
- ☐ ☐ Dandruff
- ☐ ☐ Dark circles under eyes
- ☐ ☐ Ears get red
- ☐ ☐ Easy bruising
- ☐ ☐ Eczema
- ☐ ☐ Herpes – genital
- ☐ ☐ Cold sores
- ☐ ☐ Hives
- ☐ ☐ Jock itch
- ☐ ☐ Change in Moles
- ☐ ☐ Oily skin
- ☐ ☐ Psoriasis
- ☐ ☐ Rash
- ☐ ☐ Red face
- ☐ ☐ Sensitive to bites
- ☐ ☐ Sensitive to poison ivy/oak
- ☐ ☐ Shingles
- ☐ ☐ Skin cancer
- ☐ ☐ Skin itching
- ☐ ☐ Skin dryness
- ☐ ☐ Strong body odor

HEAD, EYES & EARS:

NOW PAST

- ☐ ☐ Distorted smell
- ☐ ☐ Distorted taste
- ☐ ☐ Bad Breath
- ☐ ☐ Ear fullness
- ☐ ☐ Ear pain
- ☐ ☐ Ear ringing
- ☐ ☐ Hearing prob
- ☐ ☐ Eye pain
- ☐ ☐ Vision
- ☐ ☐ Sinus
- ☐ ☐ Migraine
- ☐ ☐ Headache
- ☐ ☐ Noise sensitive
- ☐ ☐ Jaw pain

NAILS:

NOW PAST

- ☐ ☐ Bitten
- ☐ ☐ Brittle
- ☐ ☐ Curve up
- ☐ ☐ Fungus
- ☐ ☐ Peeling
- ☐ ☐ Ridges
- ☐ ☐ Thickened
- ☐ ☐ White spots/lines

CARDIOVASCULAR:

NOW PAST

- ☐ ☐ Chest pain
- ☐ ☐ Breathlessness
- ☐ ☐ Palpitations
- ☐ ☐ Pain in calves
- ☐ ☐ Swollen ankles
- ☐ ☐ Varicose veins

RESPIRATORY:

NOW PAST

- ☐ ☐ Bad breath
- ☐ ☐ Cough
- ☐ ☐ Hay fever
- ☐ ☐ Hoarseness
- ☐ ☐ Nasal stuffiness
- ☐ ☐ Nose bleeds
- ☐ ☐ Post nasal drip
- ☐ ☐ Out of breath
  - ☐ ☐ At rest
  - ☐ ☐ With exercise
- ☐ ☐ Sinus fullness
- ☐ ☐ Sinus infection
- ☐ ☐ Snoring
- ☐ ☐ Sore throat
- ☐ ☐ Wheezing
- ☐ ☐ Winter stuffiness

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DIGESTION:

NOW PAST

- ☐ ☐ Bloating after eating
- ☐ ☐ Blood in stools
- ☐ ☐ Burping
- ☐ ☐ Constipation
- ☐ ☐ Anal itching
- ☐ ☐ Trouble chewing
- ☐ ☐ Diarrhea
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Dry mouth
- ☐ ☐ Passing gas
- ☐ ☐ Fissures
- ☐ ☐ Foods “repeat”
- ☐ ☐ Heartburn (reflux)
- ☐ ☐ Hemorrhoids
- ☐ ☐ Intolerance to:
  - ☐ ☐ Lactose
  - ☐ ☐ All milk products
  - ☐ ☐ Gluten
  - ☐ ☐ Corn
  - ☐ ☐ Eggs
  - ☐ ☐ Fatty foods
  - ☐ ☐ Other_____
- ☐ ☐ Yellow eyes/skin
- ☐ ☐ Abdominal pain
- ☐ ☐ Mucus in stools
- ☐ ☐ Nausea
- ☐ ☐ Strong stool odor
- ☐ ☐ Undigested food in stools
- ☐ ☐ Vomiting

MUSCLE/BONE:

NOW PAST

- ☐ ☐ Muscle twitching
- ☐ ☐ Muscle pain
- ☐ ☐ Joint pain
- ☐ ☐ Joint stiffness
- ☐ ☐ Tendonitis
- ☐ ☐ Back pain

MOOD/NERVES:

NOW PAST

- ☐ ☐ Difficulty:
- ☐ ☐ Concentrating
- ☐ ☐ With balance
  - ☐ ☐ With judgment
  - ☐ ☐ With memory
- ☐ ☐ Dizziness (spinning)
- ☐ ☐ Light headedness
- ☐ ☐ Fainting
- ☐ ☐ Numbness
- ☐ ☐ Anxiety
- ☐ ☐ Fearfulness
- ☐ ☐ Depression
- ☐ ☐ Suicidal thoughts
- ☐ ☐ Other Phobias
- ☐ ☐ Panic attacks
- ☐ ☐ Paranoia
- ☐ ☐ Hallucinations
- ☐ ☐ Seizures
- ☐ ☐ Tingling
- ☐ ☐ Tremor

ENDOCRINE/IMMUNE

NOW PAST

- ☐ ☐ Cold hands/ feet
- ☐ ☐ Cold or heat intolerance
- ☐ ☐ Fatigue
- ☐ ☐ Weight gain
- ☐ ☐ Get sick a lot
- ☐ ☐ Swollen lymph nodes
- ☐ ☐ Hair loss

URINARY:

NOW PAST

- ☐ ☐ Hesitancy
- ☐ ☐ Frequent UTI
- ☐ ☐ Pain/burning
- ☐ ☐ Urgency
- ☐ ☐ Leaking

MALE REPRODUCTIVE:

NOW PAST

- ☐ ☐ Discharge from penis
- ☐ ☐ Ejaculation problem
- ☐ ☐ Genital pain
- ☐ ☐ Impotence
- ☐ ☐ Lumps in testicles
- ☐ ☐ Poor libido (sex drive)

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FEMALE REPRODUCTIVE:

NOW PAST

- ☐ ☐ Breast cysts
- ☐ ☐ Breast tenderness
- ☐ ☐ Ovarian cyst
- ☐ ☐ Poor libido (sex drive)
- ☐ ☐ Pelvic pain
- ☐ ☐ Infertility
- ☐ ☐ Vaginal discharge
- ☐ ☐ Vaginal itch
- ☐ ☐ Vaginal pain

PREMENSTRUAL:

NOW PAST

- ☐ ☐ Bloating
- ☐ ☐ Breast tenderness
- ☐ ☐ Food cravings
- ☐ ☐ Sleep change
- ☐ ☐ Fatigue
- ☐ ☐ Irritability

MENSTRUAL:

NOW PAST

- ☐ ☐ Cramps
- ☐ ☐ Heavy periods
- ☐ ☐ Irregular periods
- ☐ ☐ No periods
- ☐ ☐ Spotting

MENOPAUSE:

NOW PAST

- ☐ ☐ Hot flashes
- ☐ ☐ Mood Swings
- ☐ ☐ Concentration
- ☐ ☐ Memory
- ☐ ☐ Vaginal dryness
- ☐ ☐ Painful sex
- ☐ ☐ Decreased libido
- ☐ ☐ Weight gain
- ☐ ☐ Frequent urination

PAST AND CURRENT MEDICAL DIAGNOSES

Check box if you have been diagnosed with any of the conditions below, either presently or in the past (prior to 6 months)

GASTROINTESTINAL:

NOW PAST

- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Inflammatory Bowel Disease
- ☐ ☐ Crohn's disease
- ☐ ☐ Ulcerative Colitis
- ☐ ☐ Gastritis or Peptic Ulcer Disease
- ☐ ☐ GERD (reflux)
- ☐ ☐ Celiac Disease
- ☐ ☐ Other_____

CARDIOVASCULAR:

NOW PAST

- ☐ ☐ Heart Attack
- ☐ ☐ Stroke
- ☐ ☐ Elevated Cholesterol
- ☐ ☐ Arrythmia (irregular heart rate)
- ☐ ☐ High blood pressure
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Other_____

METABOLIC/ENDOCRINE:

NOW PAST

- ☐ ☐ Type 1 Diabetes
- ☐ ☐ Type 2 Diabetes
- ☐ ☐ Hypoglycemia
- ☐ ☐ Metabolic Syndrome

METABOLIC/ENDOCRINE:

NOW PAST

- ☐ ☐ Insulin Resistance
- ☐ ☐ Hypothyroidism (low thyroid)
- ☐ ☐ Hyperthyroidism (overactive)
- ☐ ☐ Polycystic Ovarian Syndrome
- ☐ ☐ Bulimia
- ☐ ☐ Anorexia
- ☐ ☐ Binge Eating Disorder
- ☐ ☐ Eating Disorder (non-specific)
- ☐ ☐ Other_____

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CANCER:

NOW PAST

- ☐ ☐ Lung Cancer
- ☐ ☐ Breast Cancer
- ☐ ☐ Colon Cancer
- ☐ ☐ Ovarian Cancer
- ☐ ☐ Prostate Cancer
- ☐ ☐ Skin Cancer
- ☐ ☐ Other _____

GENITAL AND URINARY:

NOW PAST

- ☐ ☐ Kidney Stones
- ☐ ☐ Gout
- ☐ ☐ Interstitial Cystitis
- ☐ ☐ Frequent Urinary Tract Infections
- ☐ ☐ Frequent Yeast Infections
- ☐ ☐ Erectile Dysfunction
- ☐ ☐ or Sexual Dysfunction
- ☐ ☐ Other _____

MUSCULOSKELETAL OR PAIN

NOW PAST

- ☐ ☐ Osteoarthritis
- ☐ ☐ Fibromyalgia
- ☐ ☐ Chronic Pain
- ☐ ☐ Other _____

INFLAMMATORY/ AUTOIMMUNE:

NOW PAST

- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Autoimmune Thyroid
- ☐ ☐ Hashimoto or Graves
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Lupus SLE
- ☐ ☐ Immune Deficiency Disease
- ☐ ☐ Severe Infectious Disease
- ☐ ☐ Food Allergies
- ☐ ☐ Environmental Allergies
- ☐ ☐ Multiple Chemical Sensitivities
- ☐ ☐ Latex Allergy
- ☐ ☐ Mono or Epstein Barr
- ☐ ☐ Other Autoimmune

_____

RESPIRATORY DISEASES:

NOW PAST

- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinusitis
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Tuberculosis
- ☐ ☐ Sleep Apnea
- ☐ ☐ Other _____

SKIN DISEASES:

NOW PAST

- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Acne
- ☐ ☐ Melanoma
- ☐ ☐ Skin Cancer
- ☐ ☐ Other _____

NEUROLOGIC/MOOD:

NOW PAST

- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Bipolar Disorder
- ☐ ☐ Schizophrenia
- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ ADD/ADHD
- ☐ ☐ Autism
- ☐ ☐ Mild Cognitive Impairment
- ☐ ☐ Parkinson's Disease
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ Seizures
- ☐ ☐ Other Neurological Diagnosis

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MEDICATION AND ALLERGIES

CURRENT MEDICATIONS – USE A SEPARATE SHEET IF NECESSARY

MEDICATION	REASON FOR USE

ALLERGY INFORMATION

MEDICATION/SUPPLEMENT/FOOD	REACTION

- ☐ Prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin, Tylenol
- ☐ Prolonged use of acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)
- ☐ Use of steroids (Prednisone, inhalers) in the past
- ☐ Prolonged use of Antibiotics
- ☐ Prolonged use of Antidepressants

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PAST MEDICAL HISTORY

YOUR BIRTH HISTORY:

- ☐ Term
- ☐ Premature

Pregnancy or Birth Complications:

_____

_____

_____

_____

YOUR CHILDHOOD HISTORY

Check box if yes:

- ☐ Lots of candy or sugar as a child
- ☐ Ear infections
- ☐ Recurrent strep throat
- ☐ Lots of antibiotics
- ☐ Stomach aches
- ☐ Mono
- ☐ Other childhood illness

_____

DENTAL HISTORY

- ☐ Lots of cavities as a child
- ☐ Silver Mercury Fillings

  How many? _____
- ☐ Gold Fillings
- ☐ Root Canals
- ☐ Implants
- ☐ Tooth Pain
- ☐ Bleeding Gums
- ☐ Gingivitis
- ☐ Floss regularly

INJURIES:

- ☐ Back injury _____
- ☐ Neck injury_____
- ☐ Head injury _____
- ☐ Broken bones_____
- ☐ Other injury _____

FOR WOMEN:

OBSTETRIC HISTORY

Check box if yes and provide number of:

- ☐ Pregnancies:_____
  - ☐ Caesarean:_____
  - ☐ Vaginal deliveries:_____
  - ☐ Miscarriage:_____
  - ☐ Abortion:_____
  - ☐ Living Children:_____
- ☐ Post Partum Depression
- ☐ Toxemia
- ☐ Gestational Diabetes
- ☐ Baby over 8 pounds
- ☐ Breast Feeding

  for how long?_____

MENSTRUAL HISTORY

- ☐ Age at first period:_____
- ☐ Menses Frequency:_____

  Length:_____

Yes	No	
☐	☐	Pain
☐	☐	Clotting

- ☐ Has your period ever skipped?_____
- ☐ For how long?_____
- ☐ Last Menstrual Period:_____
- ☐ Use contraception
- ☐ Birth Control Pills
  - ☐ Currently. # Years? _____
  - ☐ Past. When? _____
- ☐ Patch
- ☐ Nuva Ring

  How long? _____
- ☐ Condom
- ☐ Diaphragm
- ☐ IUD
- ☐ Partner vasectomy

MENOPAUSE HISTORY

- ☐ Menopause, Age of last period_____
- ☐ Hormone replacement therapy
  - ☐ Currently? # Years? _____
  - ☐ Past: When? _____

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PAST SURGICAL HISTORY AND HOSPITALIZATIONS

DATE	CONDITION / REASON

PREVENTATIVE/DIAGNOSTIC TESTING

Check box if yes and provide date

- ☐ Full Physical Exam _____
- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Stress Test _____
- ☐ EBT Heart Scan _____
- ☐ EKG _____
- ☐ Hemoccult Test-stool test for blood _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Ultrasound _____

MEN'S PREVENTIVE TESTING

Check box if yes and provide the date

- ☐ Last PSA_____

  PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ > 10
- ☐ Last Prostate exam (rectal)_____

Results _____

WOMEN'S PREVENTIVE TESTING

Check box if yes and provide the date

- ☐ Last Mammogram:_____
- ☐ Need a Biopsy? Date_____
- ☐ PAP test date _____

  ☐ Normal ☐ Abnormal

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ENVIRONMENTAL OR OTHER EXPOSURES AND DETOX ASSESSMENT

ADVERSE REACTION TO:

- ☐ Caffeine:
  - ☐ Irritable ☐ Wired ☐ Aches & Pains
- ☐ Monosodium glutamate (MSG)
- ☐ Aspartame (Nutrasweet)
- ☐ Bananas ☐ Garlic ☐ Onion ☐ Cheese
- ☐ Citrus foods ☐ Chocolate ☐ Alcohol
- ☐ Red Wine
- ☐ Sulfite containing foods (wine, dried fruit, salad bars)
- ☐ Preservatives (ex. sodium benzoate)
- ☐ Other_____

YOU ARE EFFECTED BY:

- ☐ Cigarette Smoke
- ☐ Perfumes/Colognes
- ☐ Auto Exhaust Fumes
- ☐ Other: _____

IN YOUR WORK OR HOME ENVIRONMENT, ARE YOU EXPOSED TO:

- ☐ Chemicals
- ☐ Electromagnetic Radiation
- ☐ Mold

HISTORY OF:

- ☐ Jaundice (turning yellow)
- ☐ Gilbert's syndrome or a liver disorder.
- ☐ Explain_____

EXPOSURE TO HARMFUL CHEMICALS SUCH AS:

- ☐ Herbicides
- ☐ Insecticides (frequent visits of exterminator)
- ☐ Pesticides
- ☐ Organic Solvents
- ☐ Heavy Metals
- ☐ Other _____
- ☐ Chemical Name, Date, Length of Exposure

_____

_____

_____

- ☐ Dry clean your clothes frequently
- ☐ Lived or worked in a damp or moldy environment or had other mold exposures
- ☐ Do you have any pets or farm animals

_____

- ☐ Work with oil based paint as artist or painter
- ☐ History of drinking problem (see Lifestyle section for detailed questions)

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SOCIAL AND PERSONAL HISTORY

RELATIONSHIPS

☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long Term Partnership

List Children:

CHILD'S NAME	AGE	GENDER

Who is living in Household? Number_____

Names _____

Their Employment/Occupation: _____

Where do you find emotional support? Check all that apply:

☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

LIFESTYLE AND SELF-CARE

SMOKING

☐ Currently Smoking
- ☐ How many years? _____
- ☐ Packs per day: _____
- ☐ Attempts to quit:_____

_____

☐ Previous Smoking:
- ☐ How many years?_____
- ☐ Packs per day?_____
- ☐ 2nd Hand smoke exposure

_____

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ALCOHOL INTAKE:

☐ How many drinks currently per week?

1 drink = 5 ounces wine, 12 oz beer, 1.5 ounces spirits

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10

PREVIOUS ALCOHOL INTAKE:

☐ Mild ☐ Moderate ☐ High ☐ None

☐ Been told you should cut down your alcohol intake

☐ Feel guilty about your alcohol consumption

☐ Have been unable to remember what you did during a drinking episode

☐ Get into arguments or physical fights when you have been drinking

☐ Been arrested or hospitalized because of drinking

☐ Thought about getting help to control or stop your drinking

OTHER SUBSTANCES

☐ Caffeine intake:

Cups/day:

☐ Coffee ☐ 1 ☐ 2-4 ☐ > 4 a day

☐ Tea ☐ 1 ☐ 2-4 ☐ > 4 a day

CAFFEINATED OR DIET SODAS INTAKE:

☐ 12-oz can/bottle/day ☐ 1 ☐ 2-4 ☐ > 4 a day

☐ List favorite type: Ex. Diet Coke, Pepsi:

_____

☐ Recreational drugs

Type_____

EXERCISE, STRESS, AND SLEEP

EXERCISE - Current Exercise Program

ACTIVITY	TYPE	HOW OFTEN EACH WEEK	HOW LONG
Stretching			
Cardio / Aerobics			
Strength			
Other (Yoga, Pilates, etc.)			
Sports or Leisure Activity			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes, please describe: _____

Do you usually sweat when exercising? ☐ Yes ☐ No

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STRESS/COPING

Check all that apply

- ☐ I have been in counseling in the past
- ☐ I am currently in therapy. Describe: _____
- ☐ I have excessive amount of stress.
- ☐ I have trouble handling the stress in my life
- ☐ Daily Stressors: Rate on scale of 1-10 (10 is the worst)

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

- ☐ I practice meditation or a relaxation technique. How often? _____

Check all that apply:

☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other: _____

SLEEP

Average number of hours you sleep per night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ < 6

What time do you go to sleep? _____ Wake up? _____

- ☐ Trouble falling asleep
- ☐ Still feel tired in the morning
- ☐ Wake up during the night and can't fall back to sleep
- ☐ Snoring is an issue. You or your partner? _____
- ☐ Rely on sleeping pills

NUTRITION AND DIET

NUTRITION HISTORY

Have you ever had a nutrition consultation? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

Describe _____

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

CHECK ALL THAT APPLY:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat
☐ Gluten Restricted ☐ Vegetarian ☐ Vegan

☐ Specific Program for Weight Loss/Maintenance Type: _____

☐ Other_____

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NUTRITION AND DIET

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you avoid any particular foods? ☐ Yes ☐ No
If yes, types and reason _____

If you could only eat a few foods a week, what would they be? _____
_____

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? _____

Do you read food labels? ☐ Yes ☐ No _____

Do you cook? ☐ Yes ☐ No If no, who does the cooking? _____

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

- ☐ Fast eater
- ☐ Erratic eating pattern
- ☐ Eat too much
- ☐ Late night eating
- ☐ Dislike healthy food
- ☐ Time constraints
- ☐ Eat more than _____% meals away from home
- ☐ Travel frequently
- ☐ Non-availability of healthy foods
- ☐ Do not plan meals or menus
- ☐ Reliance on convenience items
- ☐ Poor snack choices
- ☐ Significant other or family members don't like healthy foods
- ☐ Significant other or family members have special dietary needs or food preferences
- ☐ Love to eat
- ☐ Eat because I have to
- ☐ Have a negative relationship to food
- ☐ Struggle with eating issues
- ☐ Emotional eater (eat when sad, lonely, depressed, bored)
- ☐ Eat too much under stress
- ☐ Eat too little under stress
- ☐ Don't care to cook
- ☐ Eating in the middle of the night
- ☐ Confused about nutrition advice

blum MD CENTER FOR HEALTH

Blum Center For Health
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Rye Brook, NY 10573
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Patient Intake Form

THE MOST IMPORTANT THING I SHOULD CHANGE ABOUT MY DIET TO IMPROVE MY HEALTH IS:

_____

☐ Height (feet/inches)_____
☐ Usual Weight Range +/- 5 lbs _____
☐ Highest adult weight _____
☐ Weight Fluctuations (> 10 lbs.) ☐ Yes ☐ No
☐ Current Weight _____
☐ Desired Weight Range +/- 5 lbs _____
☐ Lowest adult weight _____
☐ Body Fat % _____

NUTRITIONAL SUPPLEMENTS (VITAMINS,HERBS, HOMEOPATHY)

SUPPLEMENT/BRAND	REASON FOR USE

READINESS TO CHANGE

RATE ON A SCALE OF: 5 (VERY WILLING) TO 1 (NOT WILLING).

In order to improve your health, how willing are you to:

Significantly modify your diet:
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

Modify your lifestyle (e.g.,work demands, sleep habits)
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

Take several nutritional supplements each day
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

Practice a relaxation technique
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

Keep a record of everything you eat each day
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

Engage in regular exercise
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

Comments _____

How confident are you of your ability to organize and follow through on the above health related activities?
5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

Comments _____

3 DAY FOOD INTAKE DIARY INSTRUCTIONS:

It is important to keep an accurate record of your food and beverage intake as a part of your treatment plan. Please complete this Food Intake Diary for 3 consecutive days including one weekend day.

- List all foods and drinks, including the amount of each.
- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), coffee – (decaffeinated with sugar and 1⁄2 & 1⁄2).
- Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc.
- Be sure to include condiments (mustard, mayonnaise, relish, pickles, etc.).
- Record water intake.
- Record any symptoms that you felt throughout the day (fatigue, anxious, gas, bloating, nausea).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)
- Record any exercise you do each day, including the type of activity and its duration.

DAY 1

TIME	FOOD/BEVERAGE	AMOUNT

Bowel Movements (at what time of the day, #, form, color):

_____

Exercise (time spent, type of exercise):

_____

Symptoms (at what time of the day, describe symptom):

_____

Other comments:_____

DAY 2

TIME	FOOD/BEVERAGE AMOUNT	COMMENT

Bowel Movements (#, form, color):

_____

Exercise:

_____

Symptoms:

_____

Other comments:_____

DAY 3

TIME	FOOD/BEVERAGE AMOUNT	COMMENT

Bowel Movements (#, form, color):

_____

Exercise:

_____

Symptoms:

_____

Other comments:_____