SENARA

Nutritional Consultation Intake Form

Name_____ Date_____

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis and treatment plan. Please place the appropriate letter in the spaces provided for any symptoms you now have or have had within the last year.

O = Occasional F = Frequent C = Constant

GENERAL
___Allergies
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Loss of Sleep
___Loss of Weight
___Anxiety
___Depression
___Neuralgia
___Numbness
___Sweats
___Tremors

MUSCLE AND JOINT
___Arthritis
___Jaw Pain/Clicking
___Bursitis
___Foot Trouble
___Hernia
___Low Back Pain
___Neck Pain/Stiffness
___Pain B/W Shoulders
___Painful Tail Bone
___Poor Posture
___Sciatica
___Swollen Joints
___Spinal Curvature

PAIN OR NUMBNESS IN:
___Shoulders
___Arms
___Elbows
___Hands
___Hips
___Legs
___Knees
___Feet

GASTROINTESTINAL
___Belching/Gas
___Colon Trouble
___Constipation
___Diarrhea
___Difficult Digestion
___Distension of Abdomen
___Excessive Hunger
___Gallbladder Trouble
___Hemorrhoids
___Intestinal Worms
___Liver Trouble
___Jaundice
___Nausea
___Stomach Pain
___Poor Appetite
___Vomiting of Blood
___Vomiting
___Heartburn

EYES, EARS, NOSE & THROAT
___Asthma
___Colds
___Deafness
___Dental Decay
___Earache
___Ear Discharge
___Ear Noises
___Enlarged Glands
___Enlarged Thyroid
___Eye Pain
___Failing Vision
___Far Sightedness
___Near Sightedness
___Gum Trouble
___Hay Fever
___Hoarseness
___Nose Bleeds
___Sinus Infection
___Sore Throat
___Tonsillitis
___Nasal Obstruction

CARDIOVASCULAR
___Hardening of the Arteries
___High Blood Pressure
___Low Blood Pressure
___Pain over Heart
___Poor Circulation
___Rapid Heart Beat
___Slow Heart Beat
___Ankle Swelling

RESPIRATORY
___Chest Pain
___Constant Cough
___Spitting up Blood
___Difficult Breathing
___Spitting up Phlegm
___Wheezing

SKIN
___Bruise Easily
___Boils
___Varicose Veins
___Dryness
___Hives or Allergy
___Itching
___Rash (Skin Eruptions)

GENITO-URINARY
___Pus in Urine
___Bed-Wetting
___Blood in Urine
___Frequent Urination
___Bladder Control Trouble
___Kidney Infection/Stones
___Painful Urination
___Prostate Trouble

FOR WOMEN ONLY
Pregnant? Yes___ No___ Maybe___
___Breast Fullness/Tenderness
___Vaginal Discharge
___Excessive Menstrual Flow
___Hot Flashes
___Irregular Cycle
___Menopausal Symptoms
___Painful Menstruation

Please check any of the conditions that apply to you:

☐ Alcoholism	☐ Cold Sores	☐ Goiter	☐ Miscarriage
☐ Scarlet Fever	☐ Anemia	☐ Diabetes	☐ Multiple Sclerosis
☐ Gout	☐ Stroke	☐ Mumps	☐ Appendicitis
☐ Diphtheria	☐ Eczema	☐ Ulcers	☐ Heart Disease
☐ Tuberculosis	☐ Influenza	☐ Pleurisy	☐ Emphysema
☐ Arteriosclerosis	☐ Lumbago	☐ Malaria	☐ Lyme Disease
☐ HIV Virus	☐ Arthritis	☐ Cancer	☐ Rheumatic Fever
☐ Pneumonia	☐ Measles	☐ Cholera	☐ Venereal Disease
☐ Fever Blisters	☐ Epilepsy	☐ Polio	☐ Whooping Cough
☐ Hysterectomy	☐ Mental Illness	☐ Cataracts	☐ Chronic Fatigue
☐ Fibromyalgia	☐ Chicken Pox	☐ Migraines	☐ Crohn's Disease

Habits:	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	_____	_____	_____	_____
Coffee/tea	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs/recreational	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____
Negative Thinking	_____	_____	_____	_____
Fun	_____	_____	_____	_____
Relaxation	_____	_____	_____	_____

What activities or hobbies do you enjoy on a regular basis?_____

Date of Last:

Physical Exam_____ Blood Test _____ Urine Test_____
Spinal X-ray _____ Chest X-ray _____ Other_____

Please mark the squares that apply to you:

Mark box 1 for MILD symptoms (occurred once or twice last 6 months).
Mark box 2 for MODERATE symptoms (occurred once or twice last month).
Mark box 3 for SEVERE symptoms (chronic, occurred once or twice in last week).
Leave circles BLANK if they don't apply to you!

	1 2 3	**Group 1**
1.	☐☐☐	Acid foods upset
2.	☐☐☐	Get chilled often
3.	☐☐☐	"Lump" in throat
4.	☐☐☐	Dry mouth-eyes-nose
5.	☐☐☐	Pulse speeds after meal
6.	☐☐☐	Keyed up – fail to calm
7.	☐☐☐	Cut heals slowly
8.	☐☐☐	Gag easily
9.	☐☐☐	Unable to relax; startles easily
10.	☐☐☐	Extremities cold, clammy
11.	☐☐☐	Strong light irritates
12.	☐☐☐	Urine amount reduced
13.	☐☐☐	Heart pounds
14.	☐☐☐	"Nervous" stomach
15.	☐☐☐	Appetite reduced
16.	☐☐☐	Cold sweats often
17.	☐☐☐	Fever easily raised
18.	☐☐☐	Neuralgia-like pains
19.	☐☐☐	Staring, blinks little
20.	☐☐☐	Sour stomach often
		Group 2
21.	☐☐☐	Joint stiffness on arising
22.	☐☐☐	Muscle-leg-toe cramps at night
23.	☐☐☐	"Butterfly" stomach, cramps
24.	☐☐☐	Eyes or nose watery
25.	☐☐☐	Eyes blink often
26.	☐☐☐	Eyelids swollen, puffy
27.	☐☐☐	Indigestion soon after meals
28.	☐☐☐	Always seems hungry; feels "lightheaded" often
29.	☐☐☐	Digestion rapid
30.	☐☐☐	Vomiting frequent
31.	☐☐☐	Hoarseness frequent
32.	☐☐☐	Breathing irregular
33.	☐☐☐	Pulse slow, feels "irregular"
34.	☐☐☐	Gagging reflex slow
35.	☐☐☐	Difficulty swallowing
36.	☐☐☐	Constipation, diarrhea alternating
37.	☐☐☐	"Slow starter"

1 2 3

38. ☐☐☐Get “chilled” infrequently
39. ☐☐☐Perspire easily
40. ☐☐☐Circulation poor, sensitive to cold
41. ☐☐☐Subject to colds, asthma, bronchitis

Group 3

42. ☐☐☐Eat when nervous
43. ☐☐☐Excessive appetite
44. ☐☐☐Hungry between meals
45. ☐☐☐Irritable before meals
46. ☐☐☐Get “shaky” if hungry
47. ☐☐☐Fatigue, eating relieves
48. ☐☐☐ “Lightheaded” if meals delayed
49. ☐☐☐Heart palpitates if meals missed or delayed
50. ☐☐☐Afternoon headaches
51. ☐☐☐Overeating sweets upsets
52. ☐☐☐Awaken after few hours sleep – hard to get back to sleep
53. ☐☐☐Crave candy or coffee in afternoons
54. ☐☐☐Moods of depression – “blues” or melancholy
55. ☐☐☐Abnormal craving for sweets or snacks

Group 4

56. ☐☐☐Hands and feet go to sleep easily, numbness
57. ☐☐☐Sight frequently, “air hunger”
58. ☐☐☐Aware of “breathing heavily”
59. ☐☐☐High altitude discomfort
60. ☐☐☐Opens windows in closed rooms
61. ☐☐☐Susceptible to colds and fevers
62. ☐☐☐Afternoon “yawner”
63. ☐☐☐Get “drowsy” often
64. ☐☐☐Swollen ankles, worse at night
65. ☐☐☐Muscle cramps, worse during exercise; get “charley horses”
66. ☐☐☐Shortness of breath on exertion
67. ☐☐☐Dull pain in chest or radiating into left arm, worse on exertion
68. ☐☐☐Bruise easily, “black and blue” spots
69. ☐☐☐Tendency to anemia
70. ☐☐☐“Nose bleeds” frequent
71. ☐☐☐Noises in head, “ringing in ears”
72. ☐☐☐Tension under the breastbone, or feeling of “tightness”, worse on exertion

Group 5

73. ☐☐☐Dizziness
74. ☐☐☐Dry Skin
75. ☐☐☐Burning feet
76. ☐☐☐Blurred vision
77. ☐☐☐Itching skin and feet
78. ☐☐☐Excessive falling hair
79. ☐☐☐Frequent skin rashes
80. ☐☐☐Bitter, metallic taste in mouth in mornings
81. ☐☐☐Bowel movements painful or difficult
82. ☐☐☐Worrier, feels insecure
83. ☐☐☐Feeling queasy; headache over eyes
84. ☐☐☐Greasy foods upset
85. ☐☐☐Stools light colored
86. ☐☐☐Skin peels on foot soles
87. ☐☐☐Pain between shoulder blades
88. ☐☐☐Use laxatives
89. ☐☐☐Stools alternate from soft to watery

1 2 3

90. ☐☐☐History of gallbladder attacks or gallstones
91. ☐☐☐Sneezing attacks
92. ☐☐☐Dreaming, nightmare type bad dreams
93. ☐☐☐Bad breath (halitosis)
94. ☐☐☐Milk products cause distress
95. ☐☐☐Sensitive to hot weather
96. ☐☐☐Burning or itching anus
97. ☐☐☐Crave sweets

Group 6

98. ☐☐☐Loss of taste for meat
99. ☐☐☐Lower bowel gas several hours after eating
100. ☐☐☐Burning stomach sensations, eating relieves
101. ☐☐☐Coating on tongue
102. ☐☐☐Pass large amounts of foul-smelling gas
103. ☐☐☐Indigestion 1/2 – 1 hour after eating; may be up to 3-4 hrs.
104. ☐☐☐Mucous colitis or “irritable bowel”
105. ☐☐☐Gas shortly after eating
106. ☐☐☐Stomach “bloating” after eating

Group 7A

107. ☐☐☐Insomnia
108. ☐☐☐Nervousness
109. ☐☐☐Can’t gain weight
110. ☐☐☐Intolerance to heat
111. ☐☐☐Highly emotional
112. ☐☐☐Flush easily
113. ☐☐☐Night sweats
114. ☐☐☐Thin, moist skin
115. ☐☐☐Inward trembling
116. ☐☐☐Heart palpitates
117. ☐☐☐Increased appetite without weight gain
118. ☐☐☐Pulse fast at rest
119. ☐☐☐Eyelids and face twitch
120. ☐☐☐Irritable and restless
121. ☐☐☐Can’t work under pressure

Group 7B

122. ☐☐☐Increase in weight
123. ☐☐☐Decrease in appetite
124. ☐☐☐Fatigue easily
125. ☐☐☐Ringing in ears
126. ☐☐☐Sleepy during day
127. ☐☐☐Sensitive to cold
128. ☐☐☐Dry or scaly skin
129. ☐☐☐Constipation
130. ☐☐☐Mental sluggishness
131. ☐☐☐Hair coarse, falls out
132. ☐☐☐Headaches upon arising, wear off during day
133. ☐☐☐Slow pulse, below 65
134. ☐☐☐Frequency of urination
135. ☐☐☐Impaired hearing
136. ☐☐☐Reduced initiative

Group 7C

137. ☐☐☐Failing memory
138. ☐☐☐Low blood pressure
139. ☐☐☐Increased sex drive
140. ☐☐☐Headaches, “splitting or rending” type
141. ☐☐☐Decreased sugar tolerance

Group 7D

142. ☐☐☐Abnormal thirst

1 2 3

143. ☐☐☐Bloating of abdomen
144. ☐☐☐Weight gain around hips and waist
145. ☐☐☐Sex drive reduced or lacking
146. ☐☐☐Tendency to ulcers, colitis
147. ☐☐☐Increased sugar tolerance
148. ☐☐☐Women: menstrual disorders
149. ☐☐☐Young girls: lack of menstrual function

Group 7E

150. ☐☐☐Dizziness
151. ☐☐☐Headaches
152. ☐☐☐Hot flashes
153. ☐☐☐Increased blood pressure
154. ☐☐☐Hair growth on face or body (Female)
155. ☐☐☐Sugar in urine (not diabetes)
156. ☐☐☐Masculine tendencies (Female)

Group 7F

157. ☐☐☐Weakness, dizziness
158. ☐☐☐Chronic fatigue
159. ☐☐☐Low blood pressure
160. ☐☐☐Nails weak, ridged
161. ☐☐☐Tendency to hives
162. ☐☐☐Arthritic tendencies
163. ☐☐☐Perspiration increase
164. ☐☐☐Bowel disorders
165. ☐☐☐Poor circulation
166. ☐☐☐Swollen ankles
167. ☐☐☐Crave salt
168. ☐☐☐Brown spots or bronzing of skin
169. ☐☐☐Allergies – tendency to asthma
170. ☐☐☐Weakness after colds, influenza
171. ☐☐☐Exhaustion – muscular and nervous
172. ☐☐☐Respiratory disorders

Group 8

173. ☐☐☐Apprehension
174. ☐☐☐Irritability
175. ☐☐☐Morbid fears
176. ☐☐☐Never seems to get well
177. ☐☐☐Forgetfulness
178. ☐☐☐Indigestion
179. ☐☐☐Poor appetite
180. ☐☐☐Craving for sweets
181. ☐☐☐Muscular soreness
182. ☐☐☐Depression; feelings of dread
183. ☐☐☐Noise sensitivity
184. ☐☐☐Acoustic hallucinations
185. ☐☐☐Tendency to cry without reason
186. ☐☐☐Hair is coarse and/or thinning
187. ☐☐☐Weakness
188. ☐☐☐Fatigue
189. ☐☐☐Skin sensitive to touch

1 2 3

190. ☐☐☐Tendency toward hives
191. ☐☐☐Nervousness
192. ☐☐☐Headache
193. ☐☐☐Insomnia
194. ☐☐☐Anxiety
195. ☐☐☐Anorexia
196. ☐☐☐Inability to concentrate; confusion
197. ☐☐☐Frequent stuffy nose; sinus infections
198. ☐☐☐Allergy to some foods
199. ☐☐☐Loose joints

Female Only

200. ☐☐☐Very easily fatigued
201. ☐☐☐Premenstrual tension
202. ☐☐☐Painful menses
203. ☐☐☐Depressed feeling before menstruation
204. ☐☐☐Menstruation excessive and prolonged
205. ☐☐☐Painful breasts
206. ☐☐☐Menstruate too frequently
207. ☐☐☐Vaginal discharge
208. ☐☐☐Hysterectomy / ovaries removed
209. ☐☐☐Menopausal hot flashes
210. ☐☐☐Menses scanty or missed
211. ☐☐☐Acne, worse at menses
212. ☐☐☐Depression of long standing

Male Only

213. ☐☐☐Prostate trouble
214. ☐☐☐Urination difficult or dribbling
215. ☐☐☐Night urination frequent
216. ☐☐☐Depression
217. ☐☐☐Pain on inside of legs or heels
218. ☐☐☐Feeling of incomplete bowel evacuation
219. ☐☐☐Lack of energy
220. ☐☐☐Migrating aches and pains
221. ☐☐☐Tire to easily
222. ☐☐☐Avoids activity
223. ☐☐☐Leg nervousness at night
224. ☐☐☐Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Chemical Balance Questionnaire

Speed of healing is greatly affected by the chemical balance within the body. This chemical balance is determined,
in large part, by what you eat and drink. Please indicate the amounts and frequencies of which you partake in the following: **BE HONEST**.

	PER DAY	PER WEEK
1. Coffee (caffeinated/decaffeinated)	_____cups	_____cups
2. Tea (herbal/regular)	_____cups	_____cups
3. Soda (regular/diet/caffeine-free)	_____oz.	_____oz.
4. Sugar, sweets, desserts, candy	_____times	_____times
5. Salt, salty snacks, chips, etc.	_____servings	_____servings
6. Red meat (beef, pork, bacon, ham, etc.)	_____times	_____times
7. Chicken/fish	_____times	_____times
8. Dairy (milk, cheese, ice cream, etc,)	_____servings	_____servings
9. Water (city, well, distilled, RO, etc.)	_____glasses	_____glasses
10. Fresh fruit	_____pieces	_____pieces
11. Fresh vegetables (non-canned)	_____servings	_____servings
12. Pasta, breads (made with white flour)	_____servings	_____servings
13. Whole grain foods	_____servings	_____servings
14. Artificially sweetened products (Sweet-N-Low, Aspartame, Equal, splenda, etc.)	_____serving	_____servings
15. Fast food (McDonald's, Hardee's, etc.)	_____times	_____times
16. Do you add salt to food at mealtime?	_____Yes_____No	_____Occasionally
17. Smoking/alcohol	_____Yes_____No	_____Occasionally

Past and Current Diet

Give some examples of types of foods you were raised on ***as a child***:

Breakfast: _____

Lunch: _____

Supper:_____

Snacks:_____

Liquids: _____

Give some examples of how your eating patterns have ***changed since childhood***:

Breakfast: _____

Lunch: _____

Supper:_____

Snacks:_____

Liquids: _____

List all supplementation you are currently taking (vitamins, minerals, homeopathics, etc.):

_____

_____

_____

Major life changes (divorce, losses, trauma, etc.):

_____