comprehensivenutrition www.loryngalardi.com loryngalardi@gmail.com

HEALTH STATUS ANALYSIS FORM - WOMEN

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Age _____ Date of birth: _____ Height _____ Weight _____

Occupation: _____

Please list all persons, including ages, and pets currently living with you: _____

_____

What are your current health concerns? Please list in the order of importance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

CURRENT HEALTH HISTORY

Name(s) of other health care professionals from which you receive care _____

_____

Please list your current and past diagnoses (if any): _____

_____

Please list all current medications including dosages: _____

_____

List all OTC (over-the-counter medications) you take on a regular basis (3 – 7 days a week): _____

_____

List all of the vitamins, minerals and herbs you take along with the daily dosages: _____

_____

When was the last time you had blood work done? _____ Do you have a copy? ☐ Yes ☐ No

NUTRITION HEALTH HISTORY

Are there foods you avoid eating? ☐ No ☐ Yes If so, what are they and why? _____

_____

Do you have food allergies, restrictions, or sensitivities? ☐ No ☐ Yes If yes, please explain:

_____

Describe your typical breakfast: _____

Describe your typical lunch: _____

Describe your typical dinner: _____

Describe your typical snack(s): _____

List the foods you crave: _____ When do you crave? _____

When you are thirsty, what do you drink? _____ How much water do you drink a day? _____

Do you now, or have you ever suffered from an eating disorder? ☐ No ☐ Yes If so, explain _____

_____

LIFESTYLE & EXERCISE HISTORY

How much aerobic/cardio exercise do you do per week? ☐ 3 or more ☐ Less than 3 ☐ not exercising
Which type(s) of aerobic/cardio exercise do you do? _____

How much weight/resistance training do you do? ☐ 3 or more ☐ Less than 3 ☐ Currently not exercising
Which type(s) of weight/resistance training do you do? _____

How much core/flexibility exercise do you do? ☐ 3 or more ☐ Less than 3 ☐ Currently not exercising
Which type(s) of core/flexibility exercise do you do? _____

Do you consume alcohol? ☐ No ☐ Yes If so, how many drinks per day? _____
Do you consume caffeine? ☐ No ☐ Yes If so, what type _____ and how much per day _____
Do you smoke/use tobacco? ☐ No ☐ Yes If so, what type _____ and how much per day _____

WEIGHT HISTORY

Are you content with your current weight? ☐ Yes ☐ No If no, what is your ideal weight? _____
Does your weight fluctuate? ☐ No ☐ Yes If so, give the highest and lowest _____
What factors do you feel contribute to your changes in weight (age, exercise, nutrition, hormones, etc)? _____

_____

CARDIOVASCULAR HEALTH HISTORY

Do you have any of the following:

High blood pressure: ☐ No ☐ Yes High total cholesterol: ☐ No ☐ Yes High LDL: ☐ No ☐ Yes
High triglycerides: ☐ No ☐ Yes High Chol/HDL Ratio: ☐ No ☐ Yes Low HDL: ☐ No ☐ Yes

ENDOCRINE HEALTH HISTORY

Do you have any of the following:

Fatigue: ☐ No ☐ Yes Heat or cold intolerance: ☐ No ☐ Yes Low blood sugar: ☐ No ☐ Yes
High blood sugar: ☐ No ☐ Yes Autoimmune disorder: ☐ No ☐ Yes Thyroid condition: ☐ No ☐ Yes

STRESS AND SLEEP HISTORY

On a scale from 1 – 10 rate your daily energy level? (1 being NO energy – 10 being VERY energetic) _____
On a scale from 1 – 10 rate your daily stress level? (1 being NO stress – 10 being EXTREMELY stressed) _____
What is the source of your stress: ☐ Job ☐ Financial ☐ Family/Relationship ☐ Other
How many hours per night do you sleep? _____ What keeps you awake? _____
Do you have problems falling asleep? ☐ No ☐ Yes Do you have problems staying asleep? ☐ No ☐ Yes

GASTROINTESTINAL HEALTH HISTORY

Number of bowel movements per day? _____ If not daily, then how often? _____
Do you tend towards constipation? ☐ No ☐ Yes Are your stools loose on a regular basis? ☐ No ☐ Yes
Have you had recent changes in your bowel habits? ☐ No ☐ Yes If yes, for how long? _____

Are you experiencing any of these symptoms:

Abdominal pain/upset stomach: ☐ No ☐ Yes Gas/bloating: ☐ No ☐ Yes
Heartburn/Reflux: ☐ No ☐ Yes Nausea/vomiting: ☐ No ☐ Yes Hemorrhoids: ☐ No ☐ Yes
Have you had a colonoscopy? ☐ No ☐ Yes If yes, what were the results? _____

_____

F E M A L E H E A L T H H I S T O R Y

Do you have a history of chronic yeast infections? ☐ No ☐ Yes

Do you have a history of chronic urinary tract infections? ☐ No ☐ Yes

Are you currently or have you ever been on antibiotics for more than 6 weeks ☐ No ☐ Yes

*** If you currently are still getting your period:**

Is there any chance you could be pregnant? ☐ No ☐ Yes Are you taking the birth control pills? ☐ No ☐ Yes

Are your periods regular? ☐ No ☐ Yes Days between periods: _____ Length of flow: _____

Days of heavy bleeding: _____ Days of light bleeding: _____ Spotting: _____

Do you experience any of these symptoms before, during or after your period:

Cramping/pain:	☐ No ☐ Yes	Constipation:	☐ No ☐ Yes	Bloating:	☐ No ☐ Yes
Increased appetite:	☐ No ☐ Yes	Weight gain:	☐ No ☐ Yes	Cravings:	☐ No ☐ Yes
Fogginess:	☐ No ☐ Yes	Headaches:	☐ No ☐ Yes	Breast tenderness:	☐ No ☐ Yes
Anxiety:	☐ No ☐ Yes	Insomnia:	☐ No ☐ Yes	Nervous tension:	☐ No ☐ Yes
Depression:	☐ No ☐ Yes	Mood changes:	☐ No ☐ Yes	Irritability:	☐ No ☐ Yes

*** If you currently peri-menopausal or menopausal,** when was your last period? _____

Are you currently on any type of HRT? ☐ No ☐ Yes If so, Brand and dosage _____

Are you experiencing any of these symptoms:

Night sweats:	☐ No ☐ Yes	Hot flashes:	☐ No ☐ Yes	Insomnia:	☐ No ☐ Yes
Anxiety:	☐ No ☐ Yes	Weight gain:	☐ No ☐ Yes	Memory loss:	☐ No ☐ Yes
Mood changes:	☐ No ☐ Yes	Fatigue:	☐ No ☐ Yes	Depression:	☐ No ☐ Yes

Date of last PAP: _____ Normal results? ☐ Yes ☐ No If no, please explain _____

Date of last mammogram: _____ Normal results? ☐ Yes ☐ No If no, please explain _____

Have you had your bone density checked? ☐ No ☐ Yes Were the results normal? ☐ No ☐ Yes

G E N E T I C H E A L T H H I S T O R Y

Please list any serious health conditions your family members have experienced:

Condition:	**Family Member**	**Age of onset/age of death**

I understand that Loryn Galardi, M.S. is a clinical nutritionist and does not dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional and botanical support can be an important compliment to my medical care, I understand nutrition counseling is not a substitute for the diagnosis, treatment, or care of disease by a medical provider. I acknowledge that my physician is my primary health care provider, and is responsible for supervising all changes in diet, nutrient intake and exercise. I understand that Loryn Galardi, M.S. will keep therapy notes as a record of our work together. These notes document the topics that we talk about, interventions used, and treatment plan or any other considerations that may be helpful to your work with me. Records will be stored in a secure location. Medical records, personal information and history divulged in session to Loryn Galardi, M.S. will be kept strictly confidential unless I consent to sharing my medical and nutritional information by way of a signed release. I agree to hold Loryn Galardi, M.S. harmless for claims or damages in connection with our work together. This is a contract between myself and Loryn Galardi, M.S., and I understand that it is also a release of potential liability.

The above information is true to the best of my knowledge.

Signed: _____ Date: _____