comprehensivenutrition www.loryngalardi.com loryngalardi@gmail.com

CLEANSE HEALTH STATUS ANALYSIS FORM

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Age _____ Date of birth: _____ Height _____ Weight _____

Occupation: _____

What are your specific goals and reasons for participating in the Cleanse Program:

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

WOMEN - Is there any chance you could be pregnant? ☐ No ☐ Yes

☐ I am taking birth control pills ☐ Beginning Menopause ☐ In Menopause ☐ Finished with Menopause

CURRENT HEALTH HISTORY

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: _____

_____

NUTRITION HEALTH HISTORY

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

_____

***Are you allergic or intolerant to naturally occurring SULFUR in foods (not SULFA drugs)?** ☐ No ☐ Yes

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? _____

EXPOSURE TO TOXINS HISTORY

Have you at any time in your life or do you now live/work in an environment that may have exposed you to:

☐ Excess fluoride (fluoridated water, drops or treatments) ☐ Excess exhaust fumes

☐ Excess mercury (paints, pesticides, art supplies etc) ☐ Excess lead (paint, paint chips etc)

☐ Environmental toxins (benzene, pesticides, molds, formaldehyde, petroleum distillates)

WEIGHT HISTORY

Are you content with your current weight? ☐ Yes ☐ No If no, what is your ideal weight? _____

CARDIOVASCULAR HEALTH HISTORY

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

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

SOCIAL, LIFESTYLE & EXERCISE HISTORY

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 _____

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How many days per week do you exercise? ☐ 3 or more ☐ Less than 3 ☐ Currently not exercising
How much aerobic/cardio exercise do you do per week? ☐ 3 or more ☐ Less than 3 ☐ not exercising
(walking, jogging, biking, swimming, cross-training machine, stationary bike, stair-climber, aerobic dance class, boxing, etc)
How much weight/resistance training do you do? ☐ 3 or more ☐ Less than 3 ☐ Currently not exercising

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? _____
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? _____

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: _____